

**COUNTY OF LOS ANGELES**

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**DEPARTMENT OF MENTAL HEALTH**

<http://dmh.lacounty.gov>

Reply To: Olivia Celis-Kanm  
Phone #: (213) 738-2147

March 27, 2009

TO: Each Supervisor

FROM: Marvin J. Southard, D.S.W.  
Director of Mental Health

Patricia S. Ploehn, L.C.S.W.  
Director of Children and Family Services

SUBJECT: **KATIE A. IMPLEMENTATION PLAN**

On October 14, 2008, your Board approved the Katie A. Strategic Plan, a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement, to be accomplished over a five-year period, and offers a central reference for incorporating several instructive documents and planning efforts in this regard, including:

- Katie A. Settlement Agreement (2003)
- Enhanced Specialized Foster Care Mental Health Services Plan (2005)
- Findings of Fact and Conclusions of Law Order, 2006, issued by Federal District Court Judge Howard Matz
- Health Management Associates Report (2007)
- Katie A. Corrective Action Plan (2007)

The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

- Mental health screening and assessment
- Mental health service delivery
- Funding of services
- Training

*"To Enrich Lives Through Effective And Caring Service"*

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- Caseload reduction
- Data/tracking of indicators
- Exit criteria and formal monitoring plan

The Strategic Plan also provides that the Department of Mental Health (DMH) and the Department of Children and Family Services (DCFS) would inform your Board of any revisions to the implementation of the Strategic Plan by March 2009, and report quarterly thereafter. Since the Strategic Plan encompasses the initial Enhanced Specialized Foster Care Mental Health Services Plan and the Katie A. Corrective Action Plan, this report will also describe any significant deviations from the planning described in those documents. Please refer to Attachment A which includes the Katie A. Implementation Plan Project Data Sheets (PDSs) for more detailed information.

#### **Status of October 14, 2008 Board Letter Recommendations**

- Recommendation 1 – The conceptual framework of the Katie A. five-year Strategic Plan has been approved by the Board, Katie A. Advisory Panel, and Plaintiffs' attorneys. The Federal Court overseeing the Katie A. Settlement Agreement will receive a copy of this memo along with the detailed implementation PDSs for formal approval in May 2009.
- Recommendation 2 – Of the \$7.1 million appropriation adjustment transferred into Provisional Financial Uses (PFU) to offset Fiscal Year (FY) 2008-09 costs only \$1.1 million remains. We propose transferring any FY 2008-09 savings, identified at the close of the fiscal year, into another PFU to offset program costs in FY 2009-10.
- Recommendation 3 – DCFS was approved to fill 61 positions by the end of FY 2008-09. As of today, 24 of the 44 positions, identified for mental health screening and assessment and training purposes, to be filled by March, have been hired; 17 positions have been hired pending release; and 3 positions are pending selection. The remaining 17 positions to support mental health service delivery functions are slated to be hired between April and June 30, 2009.
- Recommendation 4 – DMH received formal notification from the Chief Executive Office (CEO) in mid-December of 2008 of the allocation of the three DMH items described in the Strategic Plan for FY 2008-09. DMH has hired one of the three positions, and has initiated the hiring process for the second item. DMH continues to work with the CEO regarding the appropriate level of the third item requested and will work to fill the position as soon as possible.

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- Recommendations 5 and 6 – The directors of DMH and DCFS received delegated authority to develop and execute contracts with mental health and training contractors to provide mental health/training related services proposed in the Strategic Plan, contingent upon funding availability. Contract amendments are currently being prepared by DMH and DCFS for Wraparound and Full-Service Partnership (FSP) providers to deliver the Wraparound/Child Family Team (CFT) service delivery provision detailed in the Strategic Plan and attached Wraparound PDS. Additional information on the status of training efforts is described later in this memo under “Training.”
- Recommendation 7 – The CEO was directed to develop and pursue legislative, regulatory, and administrative proposals seeking to maximize revenue reimbursement from the state, particularly for Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) funds. As discussed in the Legislative Advocacy PDS, the CEO has been working closely with County Counsel and the departments, and a policy proposal has been drafted by County Counsel examining whether a Medi-Cal State Plan amendment is required to issue higher reimbursement rates to mental health providers delivering specialty mental health services to children in Wraparound programs as part of the Medi-Cal Schedule of Maximum Allowances. More detail on how to implement a higher reimbursement rate structure will be developed in the coming months.
- Recommendation 8 – DCFS and DMH conducted an all-day joint Learning Organization Group (LOG) on the Katie A. Strategic Plan on December 1, 2008 for regional management and program staff which was attended by 238 individuals. The conference was well-received and based on a five-point Likert Scale with (1) being very poor and (5) very good, the average ratings for the seven topical assessment areas measuring conference effectiveness averaged 4.11 or higher. DCFS and DMH program managers have subsequently been conducting meetings on a weekly basis with regional staff at the various offices to pick up where the LOG left off regarding barriers to implementation, departmental roles and responsibilities, and to prepare offices for the future rollout of the Katie A. Strategic Plan. To date, 12 meetings have been conducted with the regional offices, and the office visits are expected to conclude in early May 2009.
- Recommendation 9 – The Departments have been directed to conduct annual assessments beginning in January 2010 to evaluate the effectiveness of Strategic Plan implementation, plan financing, and status of efforts to maximize revenue reimbursement. In the interim, quarterly reports will be submitted on implementation activities by June 30, 2009 and September 30, 2009.

### **Status of Implementation of Strategic Plan Provisions**

#### **Mental Health Screening and Assessment**

The Plan describes a systematic process by which all children on new and currently open DCFS cases will be screened and/or assessed for mental health services. A number of programs have been developed to facilitate this process, which are described in greater detail in the following nine PDSs: 1) Medical Hubs; 2) Coordinated Services Action Team (CSAT); 3) Multidisciplinary Assessment Team (MAT); 4) Referral Tracking System (RTS); 5) Consent; 6) Benefits Establishment; 7) D-Rate; 8) Team Decision-Making (TDM) and Resource Management Process (RMP); and 9) Specialized Foster Care.

We are pleased to report that significant progress has been made by each of these project teams. By effectively managing the hiring process in coordination with the development of policy, training, and a data tracking system, the Departments are on schedule to meet the goals of systematically screening and assessing children. For example, the Departments have developed a process by which Katie A. related documents can be reviewed across department lines and issued concurrently. In particular, much progress has been made related to the completion and documentation of the Mental Health Screening Tool (MHST); the complicated issues of consent for mental health services and the authorization of release of mental health records; identifying crucial data fields for the Referral Tracking System (RTS), which when developed, will enable CSAT staff to track and provide reliable data through an automated system; an improved Psychotropic Medication Authorization (PMA) process managed through the D-Rate Program; clarification of the respective roles of the DCFS and DMH staff in the Resource Management Process; and the roles and responsibilities of the co-located DMH staff housed in DCFS regional offices.

Two screening and assessment components vary from the Strategic Plan. The Strategic Plan describes the rollout of the CSAT to begin (Phase One) according to the following schedule in the selected offices:

- SPA 7 – Belvedere and Santa Fe Springs were trained in March 2009
- SPA 6 – Wateridge and Vermont Corridor offices will be trained in April 2009
- SPA 6 – Compton will be trained in May 2009
- SPA 1 – Palmdale and Lancaster will be trained in June 2009

The rollout schedule has been changed slightly to allow for greater opportunities to learn from the experience of the SPA 7 implementation. The SPA 7 schedule will remain as is; however, the schedule for the following offices has been revised as follows:

- SPA 6 – Wateridge and Vermont Corridor offices will be trained in May 2009
- SPA 6 – Compton will be trained in June 2009

- SPA 1 – Palmdale and Lancaster will be trained in July 2009

Program implementation will commence the month following staff training.

Additionally, as noted in the Corrective Action Plan, and reiterated in the last update to the Board in June 2008, the Countywide expansion of the MAT program was anticipated to be rolled out in SPAs 1 and 7 by February 2009 and in the remaining SPAs by June 2009. In SPAs 1 and 7, providers have been identified, contracts amended, and training completed and referrals are beginning to be made to these agencies. In SPAs 2, 4, and 8, MAT providers have been identified and DMH is in the process of amending contracts and scheduling training for these new MAT providers. It is expected that these three SPAs will be able to implement MAT by the end of this fiscal year, with only SPA 5, with a projected implementation timeline of first quarter of FY 2009-10, behind the original projected timeline.

As depicted in Attachment B, the number of referrals to the MAT program has more than tripled in the last three years since program inception. This increase in program efficiency is directly attributable to the hiring of DCFS and DMH MAT Coordinators in SPAs 6 and 3, where the MAT program was already in place. Note that the data reported in Attachment B for FY 2008-09 is only for the first six months of the fiscal year and that if we extrapolate this figure over the entire fiscal year the total number of MAT referrals for the current fiscal year would, conservatively, double from the number reported here to over 1,800 referrals.

### **Mental Health Service Delivery**

The Mental Health Service Delivery section of the Strategic Plan describes an expansion of the existing Wraparound program by 2,800 additional slots, to be accomplished over the course of the next five years, using a three-tiered model with tiers ranging in intensity of service based upon the child's needs. Tier One represented the current Wraparound Program and was described as being the appropriate choice for those children with the most intensive service needs; while Tier Two, funded with a case rate and EPSDT allotment, was for those children with less intensive service needs; and Tier Three, funded with Mental Health Services Act (MHSA) FSP funds as well as a monthly case rate, was described as the appropriate service level for children with the least intensive service needs. The plan described that children would be placed in one of these Wraparound/Child and Family Team (CFT) tiers based upon service need and children would be able to transition up or down from one tier to another, while maintaining the same treatment team based on changing service needs.

The three-tiered model described in the Strategic Plan has been revised to a two-tiered model as implementation of the model revealed programmatic similarity between Tier Two and Tier Three populations and unnecessary complexity of a three-tiered model. Tier One remains the same at 1,400 slots and represents the existing Wraparound Program for

children whose emotional/behavioral problems threaten placement or have resulted in an RCL 10 or above placement. Tiers Two and Three have been combined into one service level for children who do not meet the eligibility criteria for Wraparound, but present a need for intensive mental health services. The 2,800 slots consist of 2,051 DCFS created slots and 749, comprised of 523 Child plus 226 Transition Age Youth (TAY) FSP slots. (Please see the attached Wraparound PDS for more detail). A decision was made to eliminate the characterization of the tiers as targeted to children with different needs for intensive services, understanding that the assessment of service need may change quickly and repeatedly, creating an unnecessarily complicated transition between tiers. These programmatic revisions have resulted in modifications to the case rate and associated ESPDT funding for the two-tiered model (as described in the Finance PDS), which DOES NOT exceed the total funding requested or allocated in the October 2008 Board letter. The funding distributions for the tiers have been revised as follows:

- Tier One - the case rate for the 1,400 slots will remain at \$4,184 per month, inclusive of placement costs, but the EPSDT monthly allocation has been enhanced to \$2,246 per month. The costs for the \$0.7 million net County cost (NCC) increase in Tier One required EPSDT County match are fully funded within the Strategic Plan funding approved by your Board.
- Tier Two - the case rate for both the DCFS generated and DMH FSP slots has been changed to \$1,250 per month, exclusive of placement costs, and with the same monthly EPSDT allocation \$2,246 as Tier One. The total yearly cost for these 2,800 slots is \$117,466,000 of which \$43,779,000 will be derived from NCC when fully implemented.

The simplification from a three-tiered to a two-tiered model will make the administration of the model more manageable. The redistribution of funds across the two tiers makes the two-tiered service provision more equivalent, which will enable service providers to deliver whatever service intensity is required under the "Do Whatever it Takes" model for providing Wraparound, regardless of what tier a child was initially placed in. This approach also recognizes the provider practice of pooling the EPSDT allocations, regardless of tier allocation, in order to meet the needs of individual clients. Attachment C describes the types of behavioral issues a child may present to be placed in a tier one or tier two slot and the related services provided by the respective tiers in addressing the child's needs.

The timeline for the Tier Two rollout will begin in May 2009 with the provision of 25 DCFS slots per month. The Tier Two FSP slots will be available beginning in July 2009, at which time, the rollout formula will include a total of 75 slots per month comprised of 50 Tier Two FSPs and 25 DCFS generated slots.

Another intensive mental health service program, originally discussed in the Corrective Action Plan, where planned rollout of services has been slower than expected, is the

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County's Treatment Foster Care (TFC) program. Pursuant to the Findings of Fact and Conclusions of Law Order by Federal District Court Judge Howard Matz, the County was directed to develop 300 treatment foster care beds by January 2008. Presently, the County has contracted for 152 beds, but only 27 treatment foster care homes have been certified and currently only 16 children are placed in these homes.

As described in the TFC PDS, efforts to comply with the court order to develop 300 foster care beds are well underway; however, progress toward the realization of the full program will likely continue to be slow, but steady, for the following programmatic reasons, including: 1) the difficulty in the recruitment and development of foster home placements; 2) the lengthy matching process between the child and foster home; 3) the required additional foster parent training of 40 hours above foster family agency certification requirements; 4) delay in receipt of livescan clearances of foster parents; 5) the required completion of adoption home studies of resource parents prior to placement; 6) lead time needed to build awareness of program with line staff and other program staff to generate referrals; and 7) the unavailability of sufficient numbers of permanency partners for Multidimensional Treatment Foster Care placements in SPA 6. The Court-appointed Katie A. Advisory Panel is well aware of the County's difficulties in bringing up these slots. The Panel has been briefed throughout 2008 and most recently in February 2009 of the ongoing challenges. We will continue to keep the Board apprised of our efforts to expand the number of TFC slots.

### **Funding of Services**

All three Departments are closely monitoring expenditures this fiscal year and anticipate some savings for FY 2008-09. More information will be available on the anticipated savings at year-end closing. Any savings resulting from the amended implementation rollout schedules discussed above will be requested to be transferred into PFU to offset FY 2009-10 costs. Plaintiffs' attorneys' costs and anticipated duration of services, along with those of the Katie A. Panel, will be forwarded under separate cover from County Counsel as a confidential attorney client communication. We propose to use FY 2008-09 savings to cover these costs now and in future years.

As discussed in the October 2008 Board letter, it's important to note that proposed cost projections may change over the years, based on changes in foster care caseloads, implementation of prevention related activities, such as the DMH led Prevention and Early Intervention (PEI) initiative, as well as the DCFS Prevention Initiative Demonstration Program (PIDP), which in concurrence with the innovative reforms supported by the Title IV-E Waiver may help deflect new cases from entering the child welfare system. As depicted in Attachment D, the number of DCFS involved children served by DMH continues to grow, even as the total caseload of DCFS decreases.

Additionally, the expenditures related to mental health services for DCFS involved children (Attachment E) continue to increase each year. The effective utilization of the EPSDT revenue stream, in addition to the Federal Economic Stimulus Package's augmented Federal Medical Assistance Percentage (FMAP), will provide some temporary fiscal relief to the County, which can be used to offset some of the service expansion costs for Katie A. class members in FYs 2009-10 and 2010-11.

### **Training**

DMH and DCFS have worked closely together to develop a number of necessary training components relating to the Strategic Plan, including:

- a joint overview/orientation for DCFS, DMH, and contract provider staff, training to support targeted strategies (such as TDM, Structured Decision Making (SDM), concurrent planning re-design, visitation, etc.) to support the caseload reduction efforts for DCFS
- specialized training in support of the newly developed policies and practice guidelines
- specialized training for newly hired staff
- provider training to support the expansion of Wraparound
- the core practice model to support the QSR elements
- coaching and mentoring approaches to improve practice
- the development of a sophisticated tracking system to document and report on trainings, as detailed in the Training PDS

Training contracts to support the Wraparound/CFT service provision, along with the expectations of the Core Practice Model and Quality Services Review (QSR), will be operational in May 2009 prior to the rollout of the Wraparound/CFT service provision.

Training activities are on schedule to support the rollout of these various activities.

### **Caseload Reduction**

The Strategic Plan outlines a number of initiatives to be undertaken by DCFS in support of the Department's strong interest in reducing the caseloads of Children's Social Workers (CSWs). We are pleased to note that progress toward the goals described in the Strategic Plan has been made. Reductions have been made in both the screen in rate and the immediate response referral rate. The total number of children in Permanent Placement (PP) has been reduced by over one thousand. Generic caseloads have been reduced from an average of 26 children per worker to 23 children per worker, while the Emergency Response (ER) caseload has been reduced from an average of 24 children per worker to 19 children per worker.

DCFS has also made significant strides in hiring new CSWs, with 289 new CSWs hired from June through December of 2008, exceeding the goal of 160 new hires described in the Strategic Plan. As of February 2009, the CSW vacancy rate is only at three percent.

### **Data/Tracking of Indicators**

DMH and DCFS continue to work toward hiring the staff to support the development of an electronic system for tracking and reporting of data indicators. DMH has hired two of the three DMH Chief Information Office Bureau (CIOB) positions approved through the Corrective Action Plan, and the CEO and Department of Human Resources (DHR) are providing support for recruitment of the third position. DCFS has selected staff for four of the five IT positions requested in the Strategic Plan.

The Referral Tracking System described in the Strategic Plan will require systems development from both DCFS and DMH in order to automate, streamline, and track the process of screening and referral. Approximately \$500,000 from the Strategic Plan has been allocated to DMH to hire consultants to act as Project Manager, Business Analyst, and Applications Developer to provide support in developing the Katie A. database and associated cubes, and DMH has drafted a Statement of Work to support the solicitation of these consultants. We anticipate these contract staff to be available by August 2009.

DMH and DCFS, in conjunction with the Katie A. Advisory Panel, County Counsel, and plaintiffs' attorneys, are finalizing a discrete set of data indicators (as described in the Data PDS and attached Katie A. Data Inventory) that will be tracked as either formal exit criteria or contextual information as one of three prongs, described below in "Exit Criteria" for monitoring compliance with the Settlement Agreement.

### **Exit Criteria and Formal Monitoring Plan**

The Strategic Plan identifies three formal exit criteria, including the successful adoption by the Board of Supervisors of the Strategic Plan, acceptable progress on a discrete set of agreed upon data indicators and a passing score on the QSR measure.

We plan to present the Strategic Plan, with the modifications discussed in this status report, for approval by the Court in May 2009. At this time, we anticipate that the Strategic Plan and accompanying Implementation Memo and PDS will be approved by the Court.

The departments will begin to track quarterly, the attached data indicators manually, to the extent possible, until a more sophisticated application and database can be developed as described above.

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The QSR process is planned to take place in three phases, described in the attached QSR PDS. Phase One calls for the development of a tailored QSR instrument, the identification of staff responsible for the development of the protocol, the identification of training resources, the identification of and training of lead reviewers, and the development of a QSR implementation plan. These activities are expected to be completed between July 2009 and July 2010.

Phase Two, to be completed between September 2010 and December 2012, commences the administration of the QSR across the 18 DCFS Regional Offices; while Phase Three, to be completed by December 2013, consists of any follow up reviews that might be necessary to achieve passing scores.

DCFS has hired a Children's Services Administrator II (CSA) to head a new Quality Improvement Section that will have lead responsibility in implementation of the QSR process. Now that staff is in place, the QSR protocol will be detailed in the coming months including the proposed sample size, percent standard for achieving a passing score, and criteria for exiting the review process.

### **Summary**

The implementation of the Katie A. Strategic Plan is being fully executed by the Departments and progress has been made toward achievement of the Settlement Agreement objectives. The Strategic Plan has been organized into eighteen project teams, each having sponsors, managers, team members and Project Data Sheets that are updated monthly to summarize the objectives, outcomes, deliverables, resources, dependencies, risks and benefits. The Departments' steadfast oversight and collaboration are evident and rapidly moving the County toward resolution of its obligation. Quarterly reports will be provided to your Board.

Please let us know if you have any questions regarding the information contained in this report, or your staff may contact Olivia Celis-Karim, DMH Deputy Director, at (213) 738-2417 or [ocelis@dmh.lacounty.gov](mailto:ocelis@dmh.lacounty.gov).

MJS:OC:GL:nr

Attachments (A - E)

c:      Chief Executive Officer  
          County Counsel  
          Executive Officer, Board of Supervisors

# Attachment A

<b>PROJECT DATA SHEET</b>	
<b>Project Name:</b> #1- Implementation Planning	
<b>Start Date:</b> October 14, 2008	
<b>Sponsors:</b>	
Charles Sophy, DCFS, Medical Director Olivia Celis-Karim, DMH, Deputy Director	
<b>Project Managers:</b>	
Adrienne Olson, DCFS Greg Lecklitner, DMH	
<b>Background:</b>	<p>In 2008, the Los Angeles County (County) Departments of Children and Family Services (DCFS) and Mental Health (DMH) developed and received approval of the Katie A. Strategic Plan which provided a detailed plan for the implementation/delivery of mental health services over a five-year period to fulfill the objectives of the July 2003 Katie A. Settlement Agreement. The Departments have been charged to return to the Board of Supervisors in March 2009 with a detailed implementation plan. Focus will be to provide oversight and technical support, monitor and report back on the development and successful execution of 17 projects that, collectively, will fulfill the objectives outlined in the Katie A. settlement Agreement.</p>
<b>Project Objective:</b>	<b>Expected Operational Date:</b>
1. Insure successful realization, ongoing oversight and monitoring, and reporting on all activities outlined in the Katie A. Strategic Plan.  2. Oversee and monitor the implementation and institutionalization of the activities outlined in the Katie A. Strategic Plan by overseeing the development of the infrastructure that will support ongoing provision of mental health services to children in the child welfare system.	10/14/08 – 10/14/11  10/14/08 – 10/14/11
<b>Expected Outcomes:</b>	Ensure that all class members (as defined in the Katie A. Strategic Plan):
	1. Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs;  2. Receive care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;

<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>
1. Monitor, provide oversight and report on the status of eighteen (18) projects that comprise the Katie A. Implementation Plan.	Adrienne Olson Greg Lecklitter	10/14/08 – 10/14/11	In progress. The goal is to exit oversight in 2011.
2. Monitor and provide oversight of the hiring of staff to insure that all allocated Katie A. positions are filled.	Adrienne Olson Greg Lecklitter	10/14/08 – 10/14/11	In progress- weekly updates provided.
3. Conduct Katie A. Learning Organization Group event to bring together DCFS, DMH, CEO and experts to provide information on the strategic plan and receive feedback on the Katie A. Strategic/Implementation Plan	Adrienne Olson Greg Lecklitter	10/14/08 – 12/1/08	Completed 12/1/08
4. Provide the DCFS Executive Committee and Regional Administrators with electronic weekly Katie A. updates on implementation.	Adrienne Olson Greg Lecklitter	10/14/08 – 2/1/08	In progress and on-going
5. Develop and maintain Katie A. internal DCFS/DMH websites.	Adrienne Olson Greg Lecklitter	10/14/08 – 10/14/11	Completed 2008 Maintenance is on-going
6. Develop and maintain Katie A. web page on the external DCFS website.	Adrienne Olson	10/14/08 – 10/14/11	In progress
7. Develop and maintain a blog on the internal Katie A. websites.	Adrienne Olson	10/14/08 – 10/14/11	Pending, expected to go live 7/1/09
8. Conduct weekly Regional Office visits that provide the background of the Katie A. lawsuit, an overview of the strategic plan, provide a forum to receive input on local implementation.	Dr. Charles Sophy Adrienne Olson Olivia Celis-Karim Greg Lecklitter	SPAs 1, 3, 6, 7 completed by 3/10/09.  SPAs 2, 4, 5, 8, Adoptions and	In progress

		the Medical Placement Units to be completed by 5/5/09.	
9.	Develop, coordinate and deliver other strategies to communicate and effectively engage all other key stakeholders, such as the court, caregivers, providers, commissions and unions, in the process of implementing the eighteen Katie A. projects.	Adrienne Olson Greg Lecklither	10/14/08 – 10/14/11
10.	Coordinate monthly Executive Leadership Meeting: DCFS, DMH, County Counsel and CEO executive level management meet and receive status updates to ensure that a holistic and integrated vision are developed to provide mental health services to children in the child welfare system.	Miguel Santana Sheila Shima	10/14/08 – 10/14/11
10.	Coordinate meetings with Board Deputies as needed between DCFS, DMH, County Counsel and CEO to provide Katie A. updates to the Board Deputies through discussions of key strategic plan policy decisions made by the Departments' Executive Leadership and then obtain Board Deputy feedback.	Miguel Santana Sheila Shima	10/14/08 – 10/14/11
11.	Coordinate monthly Departmental Leadership Meeting: DCFS, DMH, County Counsel and CEO Katie A. management leads discuss and resolve legal, policy, program, and financial issues.	Lesley Blacher	10/14/08 – 10/14/11
12.	Coordinate semi-monthly Project Leadership Conference Call: DCFS, DMH, County Counsel and CEO management leads share critical information and develop next steps with the Advisory Panel and Plaintiff's Attorney.	Lesley Blacher	10/14/08 – 10/14/11
13.	Coordinate quarterly Panel Retreat: DCFS, DMH County Counsel and CEO executive level and management	Adrienne Olson Greg Lecklither	10/14/08 – 10/14/11

leads are to discuss and receive input on legal, policy, program and financial issues with the Advisory Panel and Plaintiff's Attorney.	Lesley Blacher		In progress and on-going
14. Coordinate weekly CHAMPS Group: DCFS, DMH, DHS, DPO, and CEO Managers coordinate implementation across departments.	Dr. Charles Sophy Olivia Celis-Karim	10/14/08 – 10/14/11	In progress and on-going
15. Coordinate monthly Joint Operational Planning meeting for DMH central and regional management providing high-level progress reports and receiving feedback for Katie A. workgroups to inform implementation planning.	Adrienne Olson Greg Lecklitner	10/14/08 – 10/14/11	In progress and on-going
16. Prepare all required reports and memoranda to inform the Board of Supervisors on the status of the implementation of the Katie A. Strategic Plan.	Adrienne Olson Greg Lecklitner Lesley Blacher	10/14/08 – 10/14/11	In progress and on-going
17. Provide the Advisory Panel with a quarterly Katie A. tracking report. DCFS, DMH, County Counsel and CEO Katie A. management leads provide updates on the status of the implementation of the Katie A. Settlement Agreement in LA County.	Elaine Magnante-Music Gary Puckett	10/14/08 – 10/14/11	In progress and on-going
<b>Resources:</b>			
1. DCFS Katie A. Administration staff consists of seven (7) full time staff: one (1) Division Chief, three (3) managers, and three (3) support staff, to oversee the 18 project that encompass the Katie A. Implementation Plan. 2. DMH has four (4) staff: two (2) District Chiefs and two (2) Program Heads to oversee the 18 projects that encompass the Katie A. Implementation Plan. 3. The CEO has identified two (2) full time staff to oversee the 18 projects that encompass the Katie A. Implementation Plan.			
<b>Dependencies:</b>			
1. All Katie A. DCFS and DMH staff vacancies are filled as scheduled. 2. Providers must have sufficient capacity to provide services for referred children and families. 3. Successfully communicate the plan and engage all stakeholders to support implementation. 4. Successful management of the seventeen other projects that make up the Implementation Plan.			
<b>Customer Benefits:</b>			
1. The County will exit oversight by the federal court.			

2. Seamless integration and provision of an array of mental health services that are culturally sensitive, tailored to individual needs and fiscally responsible.
3. Children's Social Workers will receive expert assistance from CSAT and spend less time searching for and linking clients to services.
4. Support the Departments objectives to increase safety, reduce time spent in foster care and reduce timelines to permanence.

**Issues and Risks:**

1. Failure to successfully engage stakeholders.
2. Appointment of Special Master by the court.
3. Identification of sufficient qualified staff.

PROJECT TEAM MEMBERS		
Name/Organization	Phone	E-Mail
Miguel Santana, CEO	(213) 974-4530	Msantana@ceo.lacounty.gov
Sheila Shima, DMH	(213) 974-1160	sshima@dmh.lacounty.gov
Lesley Blacher, CEO	(213) 974-4603	Lblacher@ceo.lacounty.gov
Rigo Rodriguez	(714) 504-7446	rigoberto@sbcglobal.net
Dr. Charles Sophy, DCFS	(213) 351-5614	sophyc@dcfs.lacounty.gov
Adrienne Olson, DCFS	(213) 351-5737	olsona@dcfs.lacounty.gov
Olivia Celis-Karim, DMH	(213) 738-2147	Ocelis@dmh.lacounty.gov
Greg Lecklitner, DMH	(213) 739-5466	Glecklitner@dmh.lacounty.gov

## PROJECT DATA SHEET

<b>Project Name:</b> #2- Medical Hubs	
<b>Start Date:</b> 2006	
<b>Sponsors:</b>	
Charles Sophy, DCFS, Medical Director Olivia Celis-Karim, DMH, Deputy Director Cheri Todoroff, DHS	
<b>Project Managers:</b>	
Donna Fernandez, DCFS Janel Jones, DMH Karen Bernstein, DHS	
<b>Background:</b>	<p>A countywide Medical Hub Program (Hub) has been established to provide expert medical examinations, including forensic evaluations, and care to newly detained DCFS children. The Hub ensures that children at high risk for health and mental health problems receive a thorough and comprehensive initial medical examination, including age-appropriate developmental and mental health screenings, and a forensic evaluation, if deemed appropriate, when there is an allegation of physical or sexual abuse. Hub physicians are experts in detecting and treating child abuse and neglect.</p>
<b>Project Objective:</b>	
<ol style="list-style-type: none"> <li>Increase the number of newly detained children seen at the Hubs. As of November 2008, based on DCFS data and Hub data, 64% of newly detained children received an Initial Medical Exam at a Hub. The goal is to increase the percentage to 100% of newly detained children placed within Los Angeles County</li> <li>Integration of California Institute Mental Health (CIMH) screen results into DCFS/DMH service delivery systems will ensure delivery of mental health assessments and treatment for newly detained DCFS served children.</li> </ol>	<p><b>Project Objective:</b></p> <p>1. Increase the number of newly detained children seen at the Hubs. As of November 2008, based on DCFS data and Hub data, 64% of newly detained children received an Initial Medical Exam at a Hub. The goal is to increase the percentage to 100% of newly detained children placed within Los Angeles County</p> <p>2. Integration of California Institute Mental Health (CIMH) screen results into DCFS/DMH service delivery systems will ensure delivery of mental health assessments and treatment for newly detained DCFS served children.</p> <p>To be coordinated with implementation of CSAT as follows:</p> <p>SPA 7: 5/15/09 SPA 6: 6/1/09 – 7/1/09 SPA 1: 8/1/09</p>

**Expected Outcomes:**

1. DCFS served, newly detained children will receive comprehensive medical exams, including forensic evaluations, as determined needed, and age-appropriate mental health screens that addresses children's specific needs.
2. DCFS newly detained children will receive mental health assessments and appropriate treatment to meet their specific needs.
3. The health information from the Hubs will be integrated into MAT assessment document and statement of findings.

<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>
1. Implement monthly tracking of the number of children receiving an initial medical examination at a medical Hub compared to the number of newly detained children.	Donna Fernandez Karen Bernstein	Ongoing	Complete
2. Implement revised Hub policy that re-emphasizes all newly placed court involved children in out-of-home care are seen at a Hub for initial medical examinations and age-appropriate mental health screens.	Donna Fernandez	5/1/09	In progress
3. Implement a Violence Intervention Program (VIP) satellite Hub at the former MacLaren Children's Center in El Monte to serve the eastern portion of Los Angeles County.	Karen Bernstein Donna Fernandez	4/1/09 – 5/30/09	In progress Renovations finished. Furniture/ equipment obtained and staffing identified. Awaiting installation of data and telephone lines.
4. Improve efficiency and coordination of care through implementation of E-mHub across the DHS Hubs.	Karen Bernstein Donna Fernandez	5/31/10	In progress Workgroup is meeting weekly, negotiations underway with vendor. Contract approval by Board of Supervisors (BOS) targeted for 5/19/09.

5. Continue to address opportunities to improve space required for the completion of examinations at Olive View UCLA Medical Center Hub.	Karen Bernstein	Ongoing	In progress Olive View Medical Center capital project, including expanded space for the Hub, to be complete FY 09-10.	SPA 3 & 6: Complete SPAs 1 & 7: 7/31/09
6. Track referrals to the Hub and to the MAT providers in each regional office at the point of detention.	Laura Andrade	1/2/09 – 7/31/09	In progress DCFS, DHS and DMH continue to work closely with the Hubs and DCFS offices to ensure smooth operations and troubleshoot as required.	
7. Implement a DCFS/ Hub Workflow Process.	Donna Fernandez Karen Bernstein	Completed	In progress Integrating with DCFS/DMH referral and tracking system compliance in all DMH co-located sites.	
8. Implement DMH CIMH follow-up procedures for the co-located units and track results in each office.	Janel Jones	Completed		
<b>Resources:</b>				
1. DCFS Program Manager of Health, Mental Health and Substance Abuse Services and two (2) staff have direct oversight of the Medical Hub Program.				
2. DHS Special Programs Director and Medical Hubs Coordinator are responsible for the Medical Hubs Program across DHS facilities, supported by the Planning and Program Oversight Deputy.				
3. Hub Medical Directors and Program Administrators, DCFS, and DMH staff meet monthly to coordinate issues across the Hubs and between departments.				
4. DMH Program Manager in the Child Welfare Division (CWD) serves part time as a liaison to the Hub, communicating the objectives and deliverables to the various managers within the CWD and the DMH Specialized Foster Care co-located sites.				

**Dependencies:**

1. Allocation in FY 2009-2010 budget for two (2) additional out-stationed CSW IIs to serve as after hours liaisons at the VIP Hub to meet the needs of ERCP.
2. Immediate DCFS internal approval of revised DCFS Hub policy.
3. Implement VIP satellite Hub immediately.
4. Timeline for implementation of E-mHub is dependent upon CEO, County Counsel, and BOs approval of the contract.
5. Implement CSAT pilot in SPA 7 by 5/1/09 and roll out in SPA 6 by 6/1/09 and SPA 1 by 8/1/09.

**Customer Benefits:**

1. Newly detained children will have their medical and emotional needs addressed by experts in a timely manner.
2. Health and mental assessment information will be integrated to assist in developing the child's case plan.
3. Each assessment and intentions will reduce time in out-of-home care and will increase permanency.

**Issues and Risks:**

1. DCFS FY 09/10 budget constraints can affect hiring of two (2) additional CSW IIs to serve the VIP Hub after hours.
2. The rollout of several large initiatives across all eight (8) SPAs will be a challenge as integration of these various programs, (MAT, Hubs, co-location of DMH staff, CSAT, referral tracking system, etc.), requires ongoing support and commitment from leadership at the County level, SPA level and across all Departments.

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<b>PROJECT DATA SHEET</b>	
<b>Project Name:</b> #3- Coordinated Services Action Team (CSAT)	
<b>Start Date:</b> April 1, 2009	
<b>Sponsors:</b>	
Charles Sophy, DCFS, Medical Director Olivia Celis-Karim, DMH, Deputy Director	
<b>Project Managers:</b>	
Janel Jones, DMH Jacqueline Wilcoxon, DMH Roberta Medina, DCFS Lisa Sorensen, DCFS	
<b>Background:</b>	<p>The development of CSAT is a result of the Health Management Association's 2007 report on the relation of the implementation of the Enhanced Specialized Foster Care Mental Health Services Plan and lack of a coordinated vision guiding the systematic mental health screening, assessment, and receipt of appropriate services. CSAT seeks to coordinate, structure, and streamline existing programs and resources to expedite mental health assessments and service linkage when a positive mental health screen or mental health trigger has been presented. While CSAT originated in the Katie A. planning process, it encourages fundamental change, beyond mental health service access and utilization, to incorporate every aspect of DCFS service delivery by simplifying service referrals/linkages for social workers. Lack of a centralized referral management structure limits the Department's ability to track service capacity, utilization rates and trends, and to make rapid adjustments as needed.</p>
<b>Project Objective:</b>	<b>Expected Operational Date:</b>
1. Create and implement CSAT teams in SPAs 1, 6 & 7 and ensure that every child on an open DCFS case in those SPAs receives a Mental Health Screening Test, is assessed if the results of the MHST are positive, referred to treatment and linked to services if necessary. For children who are in need of mental health services but have no benefits, efforts will be made to seek supportive services and to establish benefits when possible	SPAs 1, 6 & 7 – 8/1/10 SPAs 2, 3, 4, 5 & 8 - 6/1/11
<b>Expected Outcomes:</b>	
1. Maximum utilization of existing and future resources and programs.	

2. Increased ability of DCFS and DMH to rapidly and accurately identify the needs of the DCFS population, and deploy resources and services as necessary.			
3. Existing support staff will combine with newly hired staff to create teams that will assist with systems navigation to quickly identify the most appropriate available services for which an individual child and/or family is eligible.			
4. Reduced workloads for CSWs because of simplified forms, reduced numbers of case presentations and easier service authorization.			
5. Easier access for CSWs to co-located support staff.			
<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>
1. Visit each Regional Office to explain CSAT and receive feedback regarding local strengths, needs and concerns.	Dr. Charles Sophy Adrienne Olson Olivia Celis-Karim Greg Lecklitner	1/13/09- 5/5/09  Visit one office per week until all 18 offices are completed.	Weekly office visits began 1/13/09 and will continue until 5/5/09.  13 offices complete: 1/13/09 - 3/31/09
2. Develop CSAT policy for DCFS and DMH.	Guy Trimarchi Lisa Sorensen Greg Lecklitner John Coyle	7/1/08 – 3/1/09	5 offices pending: 4/1/09- 5/5/09
3. Hire Service Linkage Specialists for SPAs 1, 6 &7.	Roberta Spears-Mathews	10/14/08 – 3/1/09	Final draft complete, minor changes.
4. Develop training for CSAT members and Regional Office staff	Mark Miller Angela Shields	10/1/08 – 3/1/09	Completed
5. Complete training for regional staff and CSAT members for individual Regional Offices.	Mark Miller Angela Shields	See Training PDS for timeline	In progress
6. Begin CSAT process in each Regional Office in SPAs 1, 6 & 7.	Lisa Sorensen Roberta Spears-Mathews	Directly after training completed	Pending
7. Review data to track effectiveness of CSAT in each office, identify barriers to greater efficiency to ensure	Lisa Sorensen	Starting 5/1/09	Pending

the ongoing timely screening, assessment, linkage and delivery of mental health services. Make adjustments within each CSAT as needed.				
8. Hire Service Linkage Specialists for SPAs 3, 4, 5 & 8	Roberta Spears-Mathews	7/1/09 – 1/1/10	Pending	
9. Develop training for CSAT members and Regional Office staff for SPAs 3, 4, 5 & 8	Mark Miller Angela Shields	See PDS for Training for timeline	In progress	
10. Complete training for regional staff and CSAT members for individual Regional Offices in SPAs 3, 4, 5 & 8	Mark Miller Angela Shields	Directly after training	Pending	
11. Begin CSAT process in each Regional Office in SPAs 3, 4, 5, 8	Lisa Sorensen Roberta Spears-Mathews	Sta. Clarita/ SFV-Pomona/Glendora-Metro North-West Los Angeles-Torrance/ So. County-	Pending	
12. Review data to track effectiveness of CSAT in each office, identify barriers to greater efficiency to ensure the ongoing timely screening, assessment, linkage and delivery of mental health services. Make adjustments within each CSAT as needed.	Lisa Sorensen	Starting 1/1/10	Pending	
<b>Resources:</b>				
1. DCFCS CSA III will manage DCFS CSAT staff. 2. SLS CSA II, 7 SLS CSA IIs, MAT CSA II, 7 MAT CSA IIs, D-rate CSA Is, D-rate CSA IIs, 2 D-rate Evaluator SCSWs, 7 D-rate Clinical Evaluator CSW IIIs (26 professional staff) and 9 clerks to manage the intake of Mental Health Screening Tools, MAT assessments, D-rate re-evaluations and benefit establishment for all children. 3. DMH co-located staff in each office to provide consultation, assessment, and crisis intervention and service linkage. 4. Data tracking system (in development) to provide tracking tools for each Regional Office.				
<b>Dependencies:</b>				
1. Timely completion of policies/guidelines for Consent, Benefits and Data Tracking to ensure adequate training, reliable data tracking, ability to procure and secure benefits, and timely linkage to service providers based on preauthorized consent and release of information. 2. Support by line staff to receive timely mental health screenings, and to assist and consult with CSAT members to ensure strong				

- engagement between children, caregivers and mental health providers.
- 3. Adequate office space to house additional staff.
- 4. Continued reduction and stabilization of caseloads to afford CSWs the opportunity for increased teaming.

**Customer Benefits:**

1. CSWs will receive additional support in screening, assessing and linking children to services.
2. CSWs will be able to use time spent identifying and procuring services for families to provide direct services.
3. Service providers will have better access (through CSAT members) to real time data to plan their service array and make informed decisions regarding the number of slots allocated for DCFS children.
4. Expedited linkage to and engagement with mental health service providers due to support CSWs will receive obtaining consent, authorization for release of information and benefits establishments.
5. All children in open cases will be promptly and routinely screened for mental health needs.

**Issues and Risks:**

1. Resistance of staff to change with perception of additional work load.
2. Continued space limitations in DCFS Regional offices present logistical challenges for CSAT members.
3. County and State budget crisis could cause adverse affects on mental health services for children.

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<b>PROJECT DATA SHEET</b>		
<b>Project Name:</b> #4- Multidisciplinary Assessment Teams (MAT)		
<b>Start Date:</b> June 1, 2005		
<b>Sponsors:</b>		
Olivia Celis-Karim, DMH, Deputy Director Charles Sophy, DCFS, Medical Director		
<b>Project Managers:</b>		
Laura Andrade, DCFS Gary Puckett, DMH		
<b>Background:</b>		
The Multidisciplinary Assessment Team (MAT) Program began in June 2005 in Service Planning Area (SPA 6) offices and expanded to SPA 3 in October, 2005 and has been operational in these two SPAs for more than three years. The purpose of MAT is to provide a comprehensive assessment of each child's and family needs as a child enters foster care. MAT Teams will continue to be rolled out to all SPAs and SPAs 1 and 7 will be ready in February 2009. The remaining SPAs (2, 4, 5, and 8) are due to become operational as DMH contracted provider agencies are identified and contracts are signed, and will be county-wide in the first quarter of FY 2010.		
<b>Project Objective:</b>		
1. Maintain the timely delivery of MAT assessments in currently operational SPAs (3 and 6).  2. Begin MAT implementation in SPAs 1 and 7 by February 2009  3. Complete MAT implementation in SPAs 2, 4, 5, 8 by June 2009		
		<b>Expected Operational Date:</b>
	1/1/09 and ongoing	
	2/28/09	
	6/30/09	
<b>Expected Outcomes:</b>		
1. Children that receive MAT assessments have shorter stays in out-of-home care than those who do not receive MAT assessments. 2. Children that receive MAT assessments have greater placement stability than those who do not receive MAT assessments. 3. Children that receive MAT assessments will be linked to needed services faster.		

<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>
<b>MAT implementation in SPAs 1 &amp; 7</b>			
1. DCFS and DMH MAT staff hired and trained in SPAs 1 and 7.	Laura Andrade Gary Puckett	2/1/09	Completed
2. MAT staff in SPAs 1 and 7 trained on MAT process.	Laura Andrade Gary Puckett	2/1/09	Completed
3. MAT providers in SPAs 1 selected and contracts signed	Gary Puckett Ana Suarez	2/15/09	Completed
4. MAT providers trained on billing procedures	Gary Puckett Norma Fritzsche	2/10/09	SPA 7 – Completed SPA 1 - Pending
5. MAT cases referred to MAT providers when training is completed.	Roberta Medina Art Lieras Ana Suarez Laura Andrade Gary Puckett	2/16/09	Started
6. Full MAT implementation in SPAs 1 and 7.	Roberta Medina Art Lieras Ana Suarez Marty Nagel Paul Gaeta Laura Andrade Gary Puckett	7/31/09	Pending
<b>MAT Implementation in SPAs 2, 4, 5, and 8</b>			
1. DCFS MAT staff hired for SPAs 2, 4, 5 & 8.	Laura Andrade	2/28/09	Completed
2. DMH MAT staff hired.	Gary Puckett	3/1/09 – 6/30/09	Pending
3. DCFS MAT Staff trained for SPAs 2, 4, 5,& 8	Laura Andrade Gary Puckett	1/30/09	Completed
4. DMH MAT staff trained.	Gary Puckett	3/1/09 – 6/30/09	Pending
5. MAT providers selected by SPA District Chiefs for SPAs 2, 4, 5 & 8.	Gary Puckett SPA District Chiefs	2/6/09	Completed

6. MAT Providers have signed DMH contracts	SPA District Chiefs MAT Provider Agencies	3/1/09 – 6/30/09	Pending
7. DCFS Staff and MAT providers trained on the MAT program.	DCFS RAs District Chiefs MAT Providers DCFS Regional Staff Gary Puckett Laura Andrade	3/1/09 – 6/30/09	Pending
8. MAT providers trained on billing procedures	Gary Puckett, Norma Fritzsche, Provider Agencies	3/1/09 – 6/30/09	Pending
9. DCFS MAT cases referred to MAT providers.	DCFS RAs DMH District Chiefs MAT Provider Agencies Laura Andrade Gary Puckett	3/1/09 – 6/30/09	Pending
10. Full MAT implementation in remaining SPAs 2, 4, 5 & 8.	DCFS RAs DMH District Chiefs Provider Agencies Laura Andrade Gary Puckett	1/31/10	Pending
<b>Resources:</b>			
1. MAT CSA I, Administration, recently hired to provide central support for DCFS MAT manager, is currently being trained. 2. Fifteen (15) of seventeen (17) DCFS MAT coordinator positions have been hired. The remaining positions to be hired and trained by mid April. 3. MAT provider agencies already operating in SPAs have sufficient capacity to meet DCFS needs. 4. Current MAT providers will expand to serve other SPAs. 5. MAT providers are willing to add staff to meet DCFS demands.			
<b>Dependencies:</b>			
1. MAT contracts are signed by MAT provider agencies starting the MAT Program implementation; 2. Finalization of Consent Policy; 3. Finalization of Benefits Establishment Policy; and			

4. MAT provider capacity to meet DCFS demands.	<b>Customer Benefits:</b> <ul style="list-style-type: none"> <li>1. Children with mental health needs are assessed quickly;</li> <li>2. Quick identification of client needs and linkage to appropriate resources;</li> <li>3. Most appropriate placement for child and family needs; and</li> <li>4. Children are linked to appropriate and viable mental health services.</li> </ul> <b>Issues and Risks:</b> <ul style="list-style-type: none"> <li>1. MAT requires county wide implementation to function most efficiently.</li> <li>2. MAT requires identification of ongoing treatment funds to work efficiently.</li> <li>3. HIPPA law creates challenges in sharing of information.</li> <li>4. MAT automated system required to log and document MAT referrals and completions.</li> <li>5. Not completing other work flow processes (MHST, Consent, and Benefits Establishment) prevents effective implementation.</li> </ul>		
<b>PROJECT TEAM MEMBERS</b>			
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## PROJECT DATA SHEET

<b>Project Name:</b> #5- Referral Tracking System (RTS)		
<b>Start Date:</b> March 1, 2008		
<b>Sponsors:</b> Olivia Celis-Karim, DMH, Deputy Director Charles Sophy, DCFS, Medical Director		
<b>Project Managers:</b> Cecilia Custodio, DCFS Lisa Sorensen, DCFS John Ortega DMH Gary Puckett, DMH		
<b>Background:</b> The development of an automated and streamlined process is crucial to ensure all children entering DCFS and currently in an open DCFS case receive needed Mental Health Services (MHS). Currently, no systematic process exists to ensure these children are routinely screened, assessed, and linked to MHS across the county. There are no consistent policies and procedures, and manual logs are utilized to track and produce data. As policies and procedures are developed that delineate referral, service linkage, and quality assurance processes, staff and managers require a technologically based system to track and monitor the workflow process and ensure compliance.		
<b>Project Objective:</b>	<b>Expected Operational Date:</b>	
1. Phase 1: Build interim RTS processes on the DCFS side to eventually automate, streamline and track referral process to DMH; and build capacity on DMH side to receive this data and produce matched client linkage data.  2. Phase 2: Build automated RTS on the DMH side that aligns with the Katie A. Data Inventory to track progress, and disposition of DCFS referrals, assessments, and DMH service linkage; and to include, if granted by the State, DMH access and data entry into CWS/CMS.	4/1/09  8/1/09	
<b>Expected Outcomes:</b>		
1. Increase ability and efficiency to track workflow process to ensure all children are screened, assessed and linked to MHS as needed; 2. Simplify collection and production of data to identify/overcome barriers and demonstrate compliance in collecting discrete data		

indicators (Data Inventory) that the County is responsible to track in relation to the Katie A. Exit Conditions from the lawsuit.

<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>
<b>Phase I</b>			
1. Production of sample data run prior to implementation	Cecilia Custodio Lisa Sorensen John Ortega	2/1/09	Completed
2. Write Statement of Work (SOW) for interim tracking of mental health referrals/receipt of services and for DMH co-located staff to have access to CWS/CMS and obtain approval from County Counsel and Information Services Division (ISD).	Lisa Sorensen	3/1/09	In progress
3. Write RTS User Guide.	Lisa Sorensen	3/1/09	In progress
4. Five (5) DCFS Information Technology staff hired.	Cecilia Custodio	2/1/09	4/5 selected
5. Submit SOW to County Counsel and the State to give DCFS authority to allow DMH staff access to CWS/CMS.	Lisa Sorensen	10/1/08 – 4/1/09	In progress
6. Identify Special Project Fields within CWS/CMS to manually track referrals to and receipt of mental health services	Cecelia Custodia	3/1/09	Completed
7. Develop and provide training to DCFS/DMH SPA 7 staff.	Mark Miller Angela Shields	3/1/09	In progress
8. Pilot RTS interim processes in SPA 7 offices and produce initial reports.	Roberta Medina Art Lieras Ana Suarez Adrienne Olson Greg Lecklitner	3/1/09 – 6/1/09	In progress
9. Develop utilization and compliance reports to help manage daily operations.	Lisa Sorensen Cecilia Custodio	4/1/09	In progress
<b>Phase II</b>			

1. Write SOW and obtain approval from County Counsel and ISD.	John Ortega	12/1/08 – 3/31/09	Draft SOW submitted to County Counsel
2. Hire Project Manager.	John Ortega	3/31/09 – 5/1/09	Pending
3. Define business rules & build RTS on DMH side.	TBD Project Manager	5/1/09 – 10/1/09	Pending
4. Develop Training.	Mark Miller Angela Shields	TBD	Pending
5. Provide Training.	Mark Miller Angela Shields	TBD	Pending
6. Pilot Phase II RTS in SPA 7.	TBD	TBD	Pending
<b>Resources:</b>	<b>Five (5) DCFS IT staff approved for hire to help support, (in part), development and ongoing work of RTS.</b> <b>2. Service Linkage Specialist (SLS) CSA II, seven (7) SLS CSA IIs, and seven (7) screening clerks approved for hire that will collect and enter data, oversee process and troubleshoot.</b> <b>3. DMH Project Manager and other IT Staff approved for hire.</b>		
<b>Dependencies:</b>	<ol style="list-style-type: none"> <li>Phase I: Timely completion of policies/procedures for completion of MH Screening, Consent, Benefits Establishment to meet deadlines for system to be built, and training to be developed and provided to staff.</li> <li>Phase I: Ability on DCFS management side to absorb additional duties prior to new IT and management staff being hired.</li> <li>Phase 2: SOW pending approval from County Counsel.</li> <li>Phase 2: Project Manager on DMH side to be hired.</li> <li>Phase 2: State approval for DMH staff to access and enter data into CWS/CMS.</li> </ol>		
<b>Customer Benefits:</b>	<ol style="list-style-type: none"> <li>Consistent practice for client referral that produces results;</li> <li>Streamlined and automated process to ease workload; and</li> <li>Administrative support/oversight and data collection to ensure accountability and fulfillment of responsibilities by all team members.</li> </ol>		
<b>Issues and Risks:</b>	<ol style="list-style-type: none"> <li>The Departments are unable to track and produce reports to demonstrate all open cases are screened, assessed and linked as needed to MHS without RTS.</li> <li>SACWIS regulations prevent the creation of the most efficient system possible and create technological barriers.</li> </ol>		

3. HIPPA law creates challenges in sharing of information.
4. Resistance of staff to change with perception of additional work load.
5. Risk of not completing other work flow processes (MHST, Consent, Benefits Establishment) prevents completion of project.

#### **PROJECT TEAM MEMBERS**

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## PROJECT DATA SHEET

<b>Project Name:</b> #6- Consent/Release of Information			
<b>Start Date:</b> March 1, 2008			
<b>Sponsors:</b>			
Dr. Charles Sophy, DCFS, Medical Director Olivia Celis-Karim, DMH, Deputy Director			
<b>Project Managers:</b>			
Greg Lecklitner, DMH Lisa Sorensen, DCFS			
<b>Background:</b>	<p>One of the issues that frequently causes delays in assessment and treatment of DCFS children is the lack of consent to authorize DMH and its providers to provide mental health services. Many providers have required court orders for assessment and/or treatment in lieu of parental consent; each agency has its own forms required to authorize parental consent. Seeking court orders for treatment bypasses contact with the child's parents, when, in most mental health settings, obtaining consent for treatment is a means by which parents are typically engaged in their child's treatment. It is time consuming and an additional workload for CSWs to request consent for treatment from the court. DCFS has also identified several points within its service delivery system where different consent and release of information forms are needed (such as Wraparound and Family Preservation).</p>		
<b>Project Objective:</b>	<b>Expected Operational Date:</b>		
<ol style="list-style-type: none"> <li>1. Create one Consent form and one Release of Protected Health Information form that can be used by all DCFS programs, DMH directly operated services and contracted providers.</li> <li>2. Change DCFS, Dependency Court, DMH and DMH providers practice standards to first seek consent and engagement with parents before turning to the courts for permission to treat DCFS dependents.</li> </ol>	<table border="1"> <tr> <td>3/1/09</td> </tr> <tr> <td>6/1/09</td> </tr> </table>	3/1/09	6/1/09
3/1/09			
6/1/09			
<b>Expected Outcomes:</b>			
<ol style="list-style-type: none"> <li>1. As children are screened for possible mental health needs, they will be assessed and linked to service without delay due to lack of consent for treatment and authorization for release of information.</li> <li>2. Parents will be more readily involved in the child's therapy, which will lead to earlier reunification and a shorter duration for family maintenance cases.</li> <li>3. DMH and provider agencies will be able to better predict how many slots they will need to serve children and slots will be filled</li> </ol>			

more quickly with fewer delays around consent and authorization to release information.			
<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>
1. Develop Consent for Treatment and Authorization for Release of Protected Health Information forms to be used for all services provided directly by DCFS, DMH or their provider agencies.	Adrienne Olson Greg Lecklitner	3/1/09	In progress
2. Develop language to be used in Dependency Court to request the court's order for treatment and the release of protected medical information.	Adrienne Olson Guy Trimarchi	3/1/09	In progress
3. Develop DCFS and DMH policies regarding obtaining consent and release of protected mental health information.	Guy Trimarchi John Coyle Lisa Sorensen	3/1/09	In progress
4. Meet with mental health providers to discuss the universal consent form; to understand their needs and to seek their review and comments on the forms.	Greg Lecklitner Lisa Sorensen	2/1/09 – 5/1/09	In progress
5. Develop and provide training to DCFS and DMH staff and mental health providers on the use of the new forms.	Mark Miller Angela Shields	TBD	Pending
6. Present the new forms to the Dependency Court judges and receive feedback. Explain situations in which the court's consent will still be sought.	Lisa Sorensen	TBD	Pending
7. Continue to work with DCFS and DMH staff and the provider community to further refine the use of the universal consent and release of information forms.	Greg Lecklitner Lisa Sorensen	3/1/08 – 3/15/09	In progress
<b>Resources:</b>			
1. Existing workgroup devoted to resolving issues of consent and release of information;			
2. DCFS has one policy analyst devoted to issues of health and mental health; and			
3. DMH has a contract staff devoted to writing policies.			
<b>Dependencies:</b>			
1. Providers must be willing to accept forms that are not agency specific.			

2. Courts must be willing to allow for parental consent as the first option for obtaining consent and release of information.
3. CSWs will need training that will adequately educate them on the concepts of informed consent and release of information; and how to engage parents in the process by helping them to understand the benefits of mental health treatment.
<b>Customer Benefits:</b>
1. Consistent practice for obtaining consent and release of information across all mental health providers;
2. Children and families will be able to receive mental health treatments without delay due to lack of consent/release of information;
3. Parents will be more readily engaged in their child's therapeutic process; and
4. Workload for CSWs will be reduced as fewer requests for consent for mental health treatment and release of information will need to be submitted to the court.

**Issues and Risks:**

- Without universal consent and release of information forms, children will face delays in service delivery;
- CSWs will face increased workloads as they must prepare a report for the dependency court;
- Resistance of staff to change with perception of additional workload; and
- Mental health providers may not come to a consensus regarding the content of the consent and release of information forms.

**PROJECT TEAM MEMBERS**

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<b>PROJECT DATA SHEET</b>	
<b>Project Name:</b> # 7- Benefits Establishment	
<b>Start Date:</b> March 1, 2008	
<b>Sponsors:</b>	
Olivia Celis-Karim, DMH, Deputy Director Charles Sophy, DCFS, Medical Director	
<b>Project Managers:</b>	
Lisa Sorensen, DCFS	
<b>Background:</b>	<p>The development of a process to screen for, determine and establish benefit eligibility for children and families served by DCFS has become crucial to the goal of delivering mental health services to children who need them in a timely manner. Although DCFS has always been able to establish immediate presumptive Medi-Cal eligibility for children who are detained from their parents, the Department has no current process in place to accurately determine and establish eligibility for children who are served while in their homes. At this time DCFS has been referring children and families to services that are later found to be unavailable to them due to lack of full scope Medi-Cal or other benefits. With the ability to accurately assess benefits that a child is currently receiving or is eligible for, and providing some assistance to parents and caregivers to get those benefits, more children served by DCFS will be linked to services that are available to them.</p>
<b>Project Objective:</b>	<b>Expected Operational Date:</b>
1. Phase I: Create a process for benefits determination for all new cases that can be followed using existing resources available at this time to DCFS for offices in SPAs 1, 6 & 7 and co-located DPSS Linkages staff. Refine and standardize current processes in place in these offices to address unanticipated lapses in Medi-Cal benefits for children on currently open cases.	4/1/09
2. Phase 2: Explore options with DPSS and other County partners that will allow staff located within DCFS Regional Offices to have adequate training to navigate the several different Medi-Cal programs, from enrollment to benefit re-determination, to ensure maximum opportunities for children served by DCFS to receive the services they need.	4/1/10
<b>Expected Outcomes:</b>	
1. Increase ability and efficiency to track workflow process to ensure all children are screened, assessed and linked to Mental Health	

<p>Services as needed and reduce the number of children for whom treatment is disrupted or unavailable due to lapses in Medi-Cal eligibility.</p> <p>2. Eligibility for all benefits established for children and families served by DCFS and all families eligible for Medi-Cal (through CALWorks or General Relief) or Healthy Families assisted with enrollment by staff with additional training in Medi-Cal eligibility.</p>			
<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>
<b>Phase I</b>			
1. Develop DCFS and DMH policies for benefit establishment as part of CSAT implementation in SPAs 1, 6 & 7	Guy Trimarchi Lisa Sorensen Roberta Medina John Coyle	2/1/09	In progress Draft policy created
2. Write Benefits Establishment User Guide, including directions for data entry for tracking purposes	Lisa Sorensen	3/1/09	In progress
3. Develop on-going training to DCFS Revenue Enhancement, Technical Assistants and SAAMS staff	Teresa Arevelo Roberta Medina Mark Miller	3/1/10	Will be concurrent with CSAT training
4. Provide ongoing training to DCFS Revenue Enhancement, Technical Assistants and SAAMS staff as CSAT is implemented in SPAs 1, 6 & 7	Teresa Arevelo Roberta Medina Mark Miller	4/1/10	Will be concurrent with CSAT training
5. Pilot the Benefits Establishment process in SPA 7	Roberta Medina Lisa Sorensen Roberta Spears-Mathews Laura Andrade	4/1/09	Pending
6. Analyze data from the data tracking system to establish baseline performance regarding benefits establishment, including numbers of children not eligible, not enrolled, unanticipated disenrollments and average time to resolve these issues.	Teresa Arevelo Roberta Medina Roberta Spears-Mathews Laura Andrade Lisa Sorensen	9/1/09	Data collection to begin when implementing CSAT

			Pending
7. Analysis of the most common scenarios in which benefit establishment has not been possible, has been difficult to resolve or has lapsed. Identify areas that require additional Medi-Cal eligibility expertise and determine the volume of cases affected in different scenarios.	Roberta Spears-Mathews Laura Andrade Teresa Arrevelo	12/1/09	
8. Develop recommendations to increase the efficiency of benefit eligibility Department-wide including recommendations for staffing, training and technology needed.	Lisa Sorensen	12/31/09	Pending
<b>Phase II</b>			
1. Conduct meetings with DPSS managers to define resources and areas of training needed to increase DCFS' ability to access, understand and support benefits determination and eligibility for children in relative and parent care.	Adrienne Olson Lisa Sorensen	12/1/09	In progress
2. Develop a proposal for Benefits Establishment to occur within or with greater assistance from DCFS.	Adrienne Olson Lisa Sorensen	1/1/10	
3. Consult with County Counsel regarding the proposal and revise as needed.	Adrienne Olson	2/1/10	Pending
4. Seek Board of Supervisors' (BOS) approval for proposal.	Dr. Sophy	3/1/10	Pending
5. Develop an implementation plan	Adrienne Olson Lisa Sorensen	5/1/10	Pending
<b>Resources:</b>			
1. Current Revenue Enhancement Eligibility staff, Technical Assistants and SAAMS clerks in each office. 2. Co-located DPSS Linkages staff to be housed in all DCFS offices.			
<b>Dependencies:</b>			
1. Phase I: Timely implementation of CSAT in SPA 7. 2. Phase I: Ability on DCFS management side to absorb additional duties. 3. Phase 2: Approval by BOS to implement a new plan that may have costs to the County and State associated.			

**4. Phase 2: State approval for staff in DCFS offices to have greater access to the MEDS system.**

**Customer Benefits:**

1. CSWs will not be required to navigate problems with Medi-Cal benefits.
2. More children will receive the services they need as benefits are established and maintained.
3. Decreased service delays will reduce the workload for CSWs and co-located DMH staff.

**Issues and Risks:**

1. Despite having a better Benefits Establishment process, the State budget crisis may have a negative impact on children's eligibility for benefits.
2. The State closely controls the number of users allowed to access the MEDS system.
3. Perception of additional workload may result in resistance of staff to change.
4. Many unknown issues around benefits establishment for children served by DCFS make project planning dates unreliable; plans are subject to considerable variability until more is known.

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Teresa Arevelo, DCFS		

## PROJECT DATA SHEET

<b>Project Name:</b> #8- D-Rate	
<b>Start Date:</b> March 1, 2009	
<b>Sponsors:</b>	
Charles Sophy, DCFS, Medical Director Olivia Celis-Karim, DMH, Deputy Director	
<b>Project Managers:</b>	
Tina Mosley, DCFS Kelly Butler, DMH Mariam Cardona, DMH	
<b>Background:</b>	
The D-Rate Program (D-Rate) assists to CSWs by identifying and assessing the mental health and behavioral needs of children, and ensuring that caregivers' homes meet the children's identified needs in accordance with the provisions of the Katie A. Settlement Agreement. D-Rate is a special funding category for relative and foster care providers who have received additional specialized training to provide care for children with special needs due to a mental health diagnosis.	
<b>Project Objective:</b>	<b>Expected Operational Date:</b>
1. Monitor children receiving the Specialized D-Rate payment to ensure that the rate and mental health services are appropriate.	Ongoing
2. Integrate D-Rate into the Coordinated Services Action Team (CSAT) process, providing intense focus on adequately addressing the mental health needs of high needs DCFS supervised children.	Ongoing
<b>Expected Outcomes:</b>	
1. Each child's case is reviewed/re-certified annually to evaluate progress, review and revamp goals, and to modify treatment options. 2. Increase support to regional CSWs by locating resources and linking children to services on their caseloads. 3. D-Rate evaluators have more visible roles through participation on teams on behalf of the children and caregivers. 4. Improved follow-up and linkages for DCFS children receiving psychotropic medication. 5. Improved planning and outcomes for children discharged from psychiatric hospital stays.	

<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>
1. Timely completion of D-Rate assessments	Kelly Butler Miriam Cardona	Ongoing	In progress
2. Timely completion of D-Rate re-assessments	Tina Mosley	Ongoing	In progress
3. Assist the CSW with the formulation of a case plan that will meet the child's specialized and specific needs, including three (3) to five (5) goals to be attained annually. These goals will include the provision of resources, community support and linkages, and brokerages to comprehensive and innovative mental health services.	Tina Mosley	Ongoing	In progress
4. D-Rate evaluators contact all caregivers whose children are prescribed psychotropic medications to inquire about side effects and linkages to psychiatric services.	Tina Mosley	Ongoing	In progress
5. Work with D-rate foster caregivers to help achieve improved outcomes for their children and address their needs and concerns, including direct access to a knowledgeable Clinical D-rate Evaluator to address their concerns.	Tina Mosley	Ongoing	In progress
6. D-Rate evaluators in the regional offices conduct hospital discharge teleconferences for DCFS children.	Tina Mosley	2/24/09	Ongoing
7. D-Rate evaluators assist regional staff to locate placements for children with mental health needs.	Tina Mosley	Ongoing	In progress
8. D-Rate evaluators identify caregivers to potentially become D-Rate certified.	Tina Mosley	Ongoing	In progress
9. D-Rate evaluators will have more visible role through participation on teams on behalf of the children and caregivers.	Tina Mosley	Ongoing	In progress

		Ongoing	In progress
10. D-Rate evaluators to assist in resolving issues related to children discharged from psychiatric hospitalization without sufficient psychotropic refill amount.	Tina Mosley	Ongoing	In progress
11. D-Rate evaluators to complete 40 day follow up court report and monthly phone contact with caregiver/child regarding Psychotropic Medication Follow-Up questionnaire.	Tina Mosley	Ongoing	In progress
<b>Resources:</b>			
<ol style="list-style-type: none"> <li>One (1) CSA II – D-Rate to act as central administrator for the D-rate program;</li> <li>One (1) STC supports CSA II;</li> <li>One (1) CSA 1 to oversee hospital discharge teleconferences, Rate Classification Level 14 Screening Process;</li> <li>Two (2) SCSW's oversee 8 D-Rate evaluators each;</li> <li>Sixteen (16) D-rate CSW IIs – conduct D-Rate re-evaluations and perform duties related to the Psychotropic Medication Authorization Process;</li> <li>Two (2) SCSW's support SCSWs and D-Rate evaluators</li> <li>Two (2) STCs reclassified from existing ITCs to carryout additional duties related to Psychotropic Medication Authorization Process;</li> <li>One (1) STC to carryout additional duties related to Psychotropic Medication Authorization Process; and</li> <li>DMH staff to provide the initial assessment to determine the child's D-rate eligibility.</li> </ol>			
<b>Dependencies:</b>			
<ol style="list-style-type: none"> <li>CSWs must refer children to the D-Rate unit for initial assessments with DMH;</li> <li>Caregivers must be available for D-Rate evaluators to complete the annual re-assessment;</li> <li>CSW and caregivers to work collaboratively with D-Rate staff to obtain updated information on psychotropic medication;</li> <li>Hospitals must report DCFS admissions for teleconferencing and discharge planning;</li> <li>Region to contact D-Rate unit for assistance on high end cases on an ongoing basis;</li> <li>DMH to complete timely initial assessments;</li> <li>Systems Linkage Specialists to include D-Rate staff in CSAT process; and</li> <li>Edelman's Children's Court to notify D-Rate Psychotropic Medication Authorization clerks of the 40-day progress report date in a timely manner.</li> </ol>			
<b>Customer Benefits:</b>			
<ol style="list-style-type: none"> <li>Children with severe mental health needs will be assessed and re-assessed on an ongoing basis to ensure receipt of timely and adequate mental health linkages and services;</li> </ol>			

2. CSWs will receive improved case planning support for children with mental health needs; and
3. Each child receiving psychotropic medication will receive follow up from D-Rate evaluators to ensure each child is provided linkages when needed.
4. Adhere to requirement to reduce foster care payment rate as children's mental health functioning improves.

**PROJECT TEAM MEMBERS**

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## PROJECT DATA SHEET

**Project Name:** #9- Resources Management Process (RMP)

**Start Date:** December 1, 2008

**Sponsors:**

Lisa Parrish, DCFS, Deputy Director  
 Olivia Celis-Karim, DMH, Deputy Director

**Project Managers:**

Michael Rauso, DCFS  
 Angela Shields, DMH  
 Marilynne Garrison, DCFS

**Background:**

The development of a standardized multi-disciplinary team process to review children/youth at risk of, currently in, or leaving residential care is crucial to ensure the appropriate level of mental health services, either community based services or short term residential care. The Resources Management Process (RMP) provides a standardized multi-disciplinary process that allows children/youth, their family and family supports an opportunity to participate in decision-making when a youth is at risk of entering, moving, or leaving residential care. RMP incorporates an objective placement tool, the Child and Adolescent Needs and Strengths (CANS), to support the team's decision making. Dr. John Lyons conducted a system delivery review of Los Angeles County and developed a "decision score" that is used with the CANS to assist the members in the RMP objectively identify the level of care needed. In 2008, select DCFS, DMH and community staff were trained on the CANS. Another important aspect of the RMP is the ability to bring community resources to the CSW. Due to the increase of available community based services, there has been a lack of consistent, timely and appropriate referrals to the newly created programs. The RMP creates a streamlined process, which brings the services to the RMP to expedite linkage with the appropriate mental health services.

**Project Objective:**

- |  |         |
|--|---------|
| 1. Develop a RMP policy with DMH and referral form (DCFS 174) that is used countywide  | 12/1/08 |
| 2. Mandate and standardize the RMP for all replacements of children/youth at risk of entering, currently in, or leaving an RCL 6-14. | 12/1/08 |

**Expected Outcomes:**

1. Increase ability and efficiency to link DCFS children/youth to the appropriate mental health services;
2. Decrease the number of replacements for DCFS children/youth;

**Expected Operational Date:**

3. Decrease the number of days spent in out of home care; and
4. Increase the number of community based mental health referrals.

<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>
<b>Phase I</b>			
1. Develop a RMP policy and DCFS 174	Michael Rauso Angela Shields Marilynne Garrison Guy Trimarchi John Coyle	12/1/08	Completed. Updates made to policy.
2. Train DMH co-located staff and DCFS Resources Utilization Management (RUM) staff to administer the CANS.	Rosa Nafariyeh Angela Shields David Cantu	6/1/08	On-going
3. Develop a system to track the number and outcome of RMP meetings.	Michael Rauso Marilynne Garrison Angela Shields Nina Powell-McCall Omar Santos	12/1/08	In progress
4. Community outreach to all the DCFS offices to reinforce the RMP policy and trouble shoot.	Michael Rauso Marilynne Garrison Angela Shields	1/1/09	In progress
5. Evaluate data from RMP.	Michael Rauso Angela Shields Marilynne Garrison Omar Santos	12/1/08	In progress
<b>Resources:</b>	1. Seventeen (17) DCFS RUM and seventeen (17) DMH clinicians were approved and hired to implement and complete the CANS, and support RMP objectives		
<b>Customer Benefits:</b>	1. Consistent practice for line staff; children/youth, their family and supports; DMH clinicians and our community partners in the placement and/or linkage to mental health services;		

2. RMP will focus on permanency for children in or at-risk of placement in an out-of-home care by establishing a Departmental commitment to ensure the safe return of children to family or to a permanent home without an extended stay in residential care;
3. Streamlined process to ease referrals, workload and linkage;
4. Multi-disciplinary team approach for better decision-making; and
5. RMP data will allow DCFS to evaluate the service delivery practice of children accessing foster care services and implement timely modifications for system reform.

**Issues and Risks:**

1. Without RMP:
  - Entry into residential care and referrals to community based services will be inconsistent and may not be appropriate;
  - CSW and youth/family will not benefit from a multi-disciplinary team to assist in the decision-making and understanding of the best available resources;
  - CSW must fill out redundant referral forms and be expected to understand the referral criteria of all existing and new programs;
  - Children/youth, their family and supports will not have an opportunity to contribute to the team decision-making process; and
  - Providers and other caring professionals will not be able to contribute to the team decision-making process.
2. Resistance of staff to change with perception of additional work load and perceived “loss of decision-making control.”

**PROJECT TEAM MEMBERS**

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## PROJECT DATA SHEET

<b>Project Name:</b> #10- DMH Specialized Foster Care Co-Located Programs	
<b>Start Date:</b> January 1, 2005	
<b>Sponsor:</b> Olivia Celis-Karim, DMH Deputy Director	
<b>Project Managers:</b> Janel Jones, DMH Jacqueline Wilcoxon, DMH Brad Bryant, DMH	
<b>Background:</b> The co-location of DMH staff in the DCFS regional offices (Specialized Foster Care) has been a critical component of the 2005 Enhanced Specialized Foster Care Plan, 2007 Corrective Action Plan, and the 2008 Katie A. Strategic Plan, to improve timely access to screening, assessment and appropriate mental health treatment for children involved in the DCFS child welfare system. The DMH clinical staff provides an array of mental health services including: follow-up on the CIMH screening tool; assessment; brief treatment; crisis intervention, and linkage to mental health service providers in the community. DMH staff will also attend and participate in the Team Decision-Making (TDM) meetings, and have an integral role in the RMP case planning and decision-making process.	
<b>Project Objective:</b>	<b>Expected Operational Date:</b>
1. Develop co-located DMH Specialized Foster Care Units in the eight DCFS offices in SPAs 1, 6 and 7. (Phase I)	1/1/05 – 1/1/07
2. With existing and additional staffing, reconfigure DMH ICAT programs, and develop co-located DMH Specialized Foster Care Units in the DCFS offices in SPAs 2, 3, 4, 5, and 8. (Phase II)	SPAs 2, 4 & 8 – 11/1/08 SPAs 3 & 5 – 3/1/09
<b>Expected Outcomes:</b>	
1. DMH Specialized Foster Care staff, in collaboration with CSWs, CSAT members, and community providers, will improve access to appropriate mental health treatment for children and families.	
2. More appropriate and comprehensive case planning will occur because of having mental health staffs participate as members of the TDM process.	
3. Children will have increased permanency and stability by having access to the most appropriate mental health services as soon as possible.	

<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>
1. All DMH Specialized Foster Care units will be fully staffed and operational.	Janel Jones Angela Shields Greg Lecklitner Bryan Mershon	August 1, 2009	Current positions filled. Twenty (20) additional positions allocated 7/1/09.
2. DMH Specialized Foster Care units decentralized and integrated under the local Service Area District Chief.	Janel Jones Angela Shields Greg Lecklitner Bryan Mershon	8/1/09	SPAs 3, 4, & 5 - in progress. SPA 2 & 8 - 8/1/09
3. All SFC Programs will follow consistent policies and procedures as provided in the Child Welfare Division Policies and Procedures Manual	Greg Lecklitner Janel Jones	2/1/09	Three (3) policies in progress. Consultant on board to assist.
4. DMH SFC staff will receive training, support and supervision to develop the knowledge and skills to be successful	Angela Shields Mark Miller	SPA 7: DMH/DCFS training – 3/1/09	Specific mental health training ongoing. See Training.
<b>Resources:</b>	<p>1. Administrative support from the DMH Service Areas District Chiefs and DCFS management in regional offices;</p> <p>2. DMH Child Welfare Division and DCFS Training Sections; and</p> <p>3. Program Managers are responsible for developing, and implementing program guidelines and policies, as well as clinical operations.</p>		
<b>Dependencies:</b>	<ol style="list-style-type: none"> <li>1. Approval of Clinical Program Manager positions to develop and maintain the new programs and coordinate with other important components of the Katie A Strategic Plan such as MAT, WRAP and intensive in home services.</li> <li>2. Retention of qualified and experienced clinical staff that can function in a fast paced, stressful interagency work setting.</li> <li>3. Local managers from DCFS and DMH informed and committed to working together to successfully implement the Katie A. Plan.</li> <li>4. Allocation of necessary space in the DCFS offices and assistance with the requirements of Medi-Cal certification in all offices, i.e. fire clearances, maintenance agreements, interview space, etc.</li> </ol>		
<b>Customer Benefits:</b>	<ol style="list-style-type: none"> <li>1. Children involved in the DCFS system for reason of child abuse and/or neglect will have increased mental health stability and well being, due to receiving early screening, assessment and referral to appropriate mental health services.</li> </ol>		

2. Children will have increased permanency and fewer placements, as well as a reduced risk of removal from their homes in the first place due to receiving earlier assessment and treatment for their mental health problems.
<b>Issues and Risks:</b> <ol style="list-style-type: none"><li>1. High expectations and work load on a small number of mental health staff assigned to each large office.</li><li>2. Increased severity and complexity of mental health issues presented by children and families referred to DCFS.</li><li>3. Capacity of the mental health community providers to respond to the increased demand for services.</li><li>4. Staff turnover of experienced clinicians within the mental health units.</li><li>5. High mental health needs of children/youth already placed in long term foster care and will be aging out of the system with limited resources available to meet their needs.</li><li>6. Increased workload on limited clerical support staff to meet the tracking and data entry needs of the units.</li></ol>

PROJECT TEAM MEMBERS		
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Jacqueline E Wilcoxon/DMH	213-418-4209	jwilcoxen@dmh.lacounty.gov

## PROJECT DATA SHEET

<b>Project Name:</b> #11- Wraparound Expansion
<b>Start Date:</b> May 1, 2009
<b>Sponsors:</b> Lisa Parrish, DCFS, Deputy Director Olivia Celis-Karim, DMH, Deputy Director
<b>Project Managers:</b> Michael Rauso, DCFS Angela Shields, DMH
<b>Background:</b> Wraparound started as a pilot project in Santa Clara County, California in response to the Title IV-E Waiver of the Social Security Act that permitted flexibility in the use of Aid to Families with Dependent Children, Foster Care (AFDC-FC) funds for eligible children. Senate Bill 163 (October 8, 1997) extended Wraparound to all counties in California. In Los Angeles County, Wraparound started in 1998 as a 10-child public agency pilot at MacLaren Children's Community Shelter (MCC) and in 2001 shifted to a lead provider agency model. In May 2003, there were 175 youth enrolled in Wraparound and eight contracted providers. Because of the positive outcomes Wraparound demonstrated, the County moved to expand Wraparound in 2006 to contract with 35 providers, increasing the potential number of youth served. In 2007, as part of the Katie A. Settlement Agreement, Judge Matz ordered Los Angeles County to expand the Wraparound census by 500 by June 2008 (to 1,217 slots) which was surpassed in May 2008 reaching 1,245 filled slots. In FY 08/09, Wraparound was expanded to 1,400 slots, referred to as Tier 1.
In May 2009, as indicated in the Katie A. Plan, Wraparound will expand again to serve 2,800 additional DCFS youth that have an identified intensive mental health need, have Early Periodic Screening and Testing (EPSDT) eligibility and do not meet the current Wraparound criteria of Rate Classification Level (RCL) 10 and higher. This expansion will create a tiered system to differentiate the current Wraparound population placements from the newly created criteria. Originally, the Strategic Plan proposed a three-tiered system with differing case rates and EPSDT reimbursement rates. However, after identifying implementation and practice issues, it was decided to create a two-tiered plan: <ul style="list-style-type: none"> <li>• Tier 1 - traditional Wraparound referral criteria; and</li> <li>• Tier 2 - comprised of 749 additional Full Service Partnerships (FSPs) and 2,051 DCFS generated slots for those children with</li> </ul>

intensive mental health needs who do not meet the RCL 10 or above Wraparound referral criteria. This new service provision will assist the providers, the County and the case workers in expediting services to families.	
<b>Project Objective:</b>	<b>Expected Operational Date:</b>
1. Increase the number of DCFS youth receiving Wraparound	5/1/09
<b>Expected Outcomes:</b>	
1. Increased ability and efficiency of families to care for their children; 2. Decreased number of placements and/or replacements for DCFS children/youth; 3. Decreased number of days spent in DCFS and out of home care; 4. Increased number of community based mental health linkages, both formal and informal; 5. Increased number of families that reunify and achieve permanency (reduce recidivism); and 6. Increased well being of families receiving Wraparound, including improved educational functioning.	
<b>Deliverables:</b>	
1. Develop an updated Wraparound policy	<b>Project Lead(s):</b> Michael Rauso Angela Shields Guy Trimmarchi John Coyle  <b>Planned Timeline:</b> 2/17/09  <b>Status</b> In progress
2. Develop a tracking system to account for the number of Wraparound youth enrolled and outcomes	  <b>Project Lead(s):</b> Michael Rauso Angela Shields Pam Dubin Omar Santos  <b>Planned Timeline:</b> 5/1/09  <b>Status</b> In progress
3. Develop an MOU between DCFS, Probation, and DMH for the provision of Wraparound services inclusive of case rates and EPSDT reimbursement	  <b>Project Lead(s):</b> Michael Rauso Angela Shields Patrick Lemaire  <b>Planned Timeline:</b> 3/1/09  <b>Status</b> In progress
4. Execute the extension for the current Wraparound providers with the inclusion of the new referral criteria and other program elements.	  <b>Project Lead(s):</b> Michael Rauso Angela Shields  <b>Planned Timeline:</b> 5/1/09  <b>Status</b> Draft Statement of Work submitted to County Counsel
5. Data and outcomes tracking and reporting	  <b>Project Lead(s):</b> Michael Rauso Angela Shields Pam Dubin Shirley Robertson  <b>Planned Timeline:</b> 5/1/09  <b>Status</b> In progress

<p><b>6. Training – public agency staff – Wraparound Expansion</b></p>	<p>Mark Miller Inter-University Consortium (IUC) Sherman Mikle Angela Shields David Cantu</p>	<p>4/1/09</p>	<p>Curriculum development in progress</p>
<p><b>7. Training – coaching and mentoring – provider staff</b></p>	<p>Sherman Mikle Angela Shields Shirley Robertson Mark Miller IUC</p>	<p>5/1/09</p>	<p>Curriculum review and trainer selection in progress</p>
<p><b>Resources:</b></p> <ol style="list-style-type: none"> <li>1. Seventeen (17) DCFS Wraparound staff approved for hire to implement the new Wraparound expansion.</li> <li>2. Eight (8) DMH Wraparound staff approved for hire to implement the new Wraparound expansion.</li> </ol>			
<p><b>Customer Benefits:</b></p> <ol style="list-style-type: none"> <li>1. An effective process that has been demonstrated to decrease placements/replacements for DCFS children/youth and increase the number of families that reunify, achieve permanency and decreased recidivism;</li> <li>2. Supports the family's voice and choice in plan development;</li> <li>3. Models a teaming process that promotes open communication around strengths, needs and accessing informal community supports that the family can continue after they graduate from Wraparound;</li> <li>4. Develops one comprehensive, individualized plan that coordinates all supports and resources;</li> <li>5. Wraparound will be available to more DCFS youth and their families.</li> </ol>			
<p><b>Issues and Risks:</b></p> <ol style="list-style-type: none"> <li>1. Appropriate and ongoing referrals to Wraparound.</li> <li>2. Continued collaboration with partners to address individual departmental objectives surrounding referral criteria and outcomes.</li> <li>3. Required ongoing and active participation/support by the CSW in the team process, which impacts: <ul style="list-style-type: none"> <li>• The ability of the team to meet the court's mandates in a way that aligns with the family's vision of help and is based on the family's strengths;</li> <li>• The ability of the team to expand membership and reach consensus on an intervention and without concern for contradicting a CSW's case plan;</li> <li>• The ability of the team to persevere in a crisis and continue the planning process with the family;</li> </ul> </li> </ol>			

- The ability of the family to understand the CSW's position and collectively develop a shared understanding of safety, permanency and well-being and the ways to get there together.
4. Resistance of staff to decisions made in a team and the ability to allow the team to creatively meet needs.
  5. Managing the increased Net County Costs (NCC) for the Wrap expansion of the new DCFS Tier 2 slots.

#### **PROJECT TEAM MEMBERS**

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## PROJECT DATA SHEET

**Project Name:** #112- Treatment Foster Care

**Start Date:** December 1, 2007

**Sponsors:**

Lisa Parrish, DCFS Deputy Director  
Olivia Celis-Karim, DMH Deputy Director

**Project Managers:**

Marilynne Garrison, DCFS  
Gail Blesi, DMH

**Background:**

As part of the Katie A Settlement, the federal court ordered DCFS to provide 300 intensive Treatment Foster Care (TFC) beds for children with behavioral and emotional problems. Many seriously emotionally disturbed and behaviorally challenged foster children spend too many years in the highest level group homes (RCL 12, 14 and Community Treatment Facilities). The purpose of the Intensive Treatment Foster Care (ITFC) and Multidimensional Treatment Foster Care (MTFC) Programs is to provide therapeutic foster homes for individual children (ages 10-17) who have been in a high level group homes (RCL 12, 14 and Community Treatment Facilities), or are at serious risk of this level of treatment or at risk of psychiatric hospitalization. These children have improved outcomes in less restrictive home environments. While in TFC, a single youth is the sole foster child in the home. Foster parents are specially trained and selected based on their compatibility with each youth's needs. The foster parents are supported 24/7 by the contracted foster care agencies.

The ITFC program is Countywide and placement duration of ITFC is indefinite. Children placed in ITFC homes will have access to Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based practice, when deemed clinically appropriate.

Currently limited to Service Provider Area (SPA) 6, the MTFC program will expand to SPAs 1 and 7 in the near future. MTFC is an evidence-based practice that has received the highest scientific rating by the California Evidence-Based Clearinghouse of Child Welfare. MTFC placements are short-term (6 to 12 months) and result in changing behaviors and preparing youth for placement with their family or permanent caregiver. Because it is currently available in SPA 6 only, MTFC is exclusively for youth whose permanent caregiver is located in or near SPA 6.

Efforts to comply with the court order to develop 300 foster care beds are now underway, however progress towards the realization of this Project Objective though slow, will be steady for the programmatic reasons noted below.		
<b>Project Objective:</b>		<b>Expected Operational Date:</b>
1. Develop and fill 220 ITFC Beds		12/1/07
2. Develop and fill 80 MTFC Beds		12/1/07
<b>Expected Outcomes:</b>		
<ol style="list-style-type: none"> <li>1. Increased appropriate alternative to group home placement;</li> <li>2. Increased access to behavioral intervention strategies;</li> <li>3. Reduced behavioral problems;</li> <li>4. Increased school success;</li> <li>5. Increased placement stability;</li> <li>6. Increased emotional stability;</li> <li>7. Increased reunification with parents, family members or non-related extended family members;</li> <li>8. Better relationships with family;</li> <li>9. Increased life skills (social, vocational);</li> <li>10. Reduced criminal behavior and drug use (MTFC);</li> <li>11. Increased peer relationship skills (MTFC);</li> <li>12. Increased happiness and life satisfaction; and</li> <li>13. Reduced runaways (AWOLs).</li> </ol>		
<b>Deliverables:</b>		
1. MTFC training for staff of 3 foster family agencies (FFAs)		Project Lead(s): Todd Sosna, CIMH Tunnel House, CIMH Gail Blesi, DMH CDT; Planned Timeline: 1/28/08 – 1/30/09 Status: Completed
2. TF-CBT of ITFC agencies staff		Project Lead(s): Todd Sosna, CIMH; Margaret Faye, DMH; Planned Timeline: 2/12/08, 2/5/09 Status: Initial training completed, on-going as needed
3. Institute Interagency Placement Review Team (IPRT) meetings		Project Lead(s): Virginia Baker Gail Blesi Margaret Faye RUM SCSWs Planned Timeline: 3/18/08 Status: Completed, on-going weekly teleconferences

	FFA Program Supervisors		
4. Develop and publish "For Your Information" (FYI) for programs	Virginia Baker Amara Suarez Gail Blesi	11/08	Completed
5. Develop and print brochures for ITFC program	Virginia Baker Bob Rogers	8/08	Completed
6. Develop and print brochures, handouts and PowerPoint presentations for targeted marketing of MTFC program	Gail Blesi	1/2008	Completed
7. Presentations to Regional DCFS and DMH staff who are potential referral resources (e.g., Team Decision-Making facilitators, co-located DMH units, Permanency Planning Conference (PPC) workers, etc) and Children's Law Center to inform community partners	Bob Rogers Gail Blesi Virginia Baker	4/1/08, 11/5/08, 12/3/08, 12/10/08; 1/8/09, 1/13/09, & 2/3/09	2/10/09 , 2/11/09, 2/1209, 2/19/09, 3/10/09, 3/11/09, & 3/12/09: completed; 4/7/09: scheduled; and on-going
8. Contact PPC facilitators for referrals for children meeting ITFC/MTFC criteria	Gail Blesi Virginia Baker	2/3/09 presentation	Presentation to PPC facilitators: completed, follow-up is on-going
9. Bi-Monthly DCFS/DMH Strategic Planning Update and Review meetings	Virginia Baker Gail Blesi Margaret Faye	5/12/08	In progress and on-going
10. Quarterly Providers Roundtables	Bob Rogers Virginia Baker	8/14/08	In progress and on-going quarterly
11. CMS Request to add Penny Lane to MTFC providers	Bob Rogers Margaret Faye	11/1/08	Pending
12. CMS Request to extend contracts for current agencies and add any with DMH contracts	Bob Rogers DCFS Contract Staff	1/2/09	In progress, requesting state approval
13. Request Regional Administrator's support for referrals to MTFC program via targeted in-person presentations	Bob Rogers Virginia Baker	3/31/09	Pending

	Gail Blesi Margaret Faye		
14. Develop on-line training regarding access to ITFC/MTFC for CSWs	Virginia Baker DCSF training staff	6/30/09	Pending
<b>Resources:</b>			
<ol style="list-style-type: none"> <li>1. DCFs staff consisting of one Program Manager and one Program Coordinator</li> <li>2. DMH staff consisting of one Community Development Team (composed of California Institute of Mental Health [CIMH] staff and DMH staff) and Central Authorizing Unit staff.</li> <li>3. FFAs providing MTFC staff one foster parent recruiter, one family therapist, one individual therapist, one skills trainer, and one Program Supervisor for every 10 youth placed. (The MTFC Program Supervisor leads the work of the foster parents and the MTFC treatment team, and is the point person for DCFS, attorneys, educators and all other community partners. For MTFC, FFAs are responsible for replacement training [including travel] costs and expenses associated with MTFC certification.) Five foster family agencies (three for TFC and two for MTFC) are currently contracted to:                             <ul style="list-style-type: none"> <li>• recruit and train foster parents in order to supply needed placements, and</li> <li>• staff Program Supervisors who support foster parents and mentor children while coordinating other supportive services.</li> </ul> </li> <li>4. Resource Utilization Management (RUM) staff provide consultation within each regional office, compile sufficient case information, present referrals to the IPRT and forward RUM packets to the providers for their review in consideration of a youth's placement.</li> <li>5. DMH staff to provide consultation and participate in IPRT teleconferences.</li> </ol>			
<b>Dependencies:</b>			
<ol style="list-style-type: none"> <li>1. Education of DCFS and DMH staff for sufficient number of appropriate referrals to these programs;</li> <li>2. Additional DCFS and DMH staff accommodate the administrative needs associated with each program;</li> <li>3. Identified TFC liaison with Community Care Licensing (CCL) could ameliorate challenges associated with lengthy timeframe for certification;</li> <li>4. Fast-tracking the contract process would address a major delay in the provision of TFC homes for the community; and</li> <li>5. Additional DCFS clerical assistance for efficiency.</li> </ol>			
<b>Customer Benefits:</b>			
<ol style="list-style-type: none"> <li>1. Children participating in Treatment Foster Care receive more normalizing living environments and better opportunities for permanence, with fewer placement disruptions, AWOLs, less criminal behavior and drug use.</li> <li>2. Children participating in Treatment Foster Care demonstrate better school adjustment, employment skills, improved peer</li> </ol>			

relationship skills, increased happiness and life satisfaction, and increased possibility of reunification with parents or relatives, and better likelihood of adoption.

**Issues and Risks:**

1. Without Treatment Foster Care:
  - Children will remain in group care long after benefit has been derived; and
  - DCFS will continue to pay for services that are no longer needed or effective for this population.
2. Development of needed foster home placements is challenging due to:
  - The demands that population's behavior places on the foster parents
  - Foster parents need to complete and additional 40 hours of training specifically developed for ITFC and MTFC, in addition to the training required to become a certified foster parent under the FFA,
  - Children need to have their own bedroom.
3. Delays in CCL clearances for foster parents has been a significant challenge during the initial phase of program development
4. Careful matching of the child with the foster parents takes time and requires sufficient referrals as well as available homes to choose from.
5. Low number of appropriate referrals from regional staff especially for the MTFC program as the program is relatively new and currently only available to youth whose permanent caregiver is located in SPA 6.
6. Program demands limited participation by FFAs resulting in only three identified agencies for ITFC and three for MTFC.
7. MTFC requires that the referred youth have a permanent placement to return to after treatment.
8. For MTFC, the permanent placement must reside in or around SPA 6.
9. Specialized referrals take extra attention and effort. Until staff becomes familiar with the benefits of this program, administration may need to encourage a minimum number of referrals from each regional office so that the availability of this valuable resource is highlighted and reinforced.

**PROJECT TEAM MEMBERS**

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## PROJECT DATA SHEET

<b>Project Name:</b> #13- Finance		
<b>Start Date:</b> March 2008		
<b>Sponsors:</b>		
Susan Kerr, DCFS, Senior Deputy Director Olivia Celis-Karim, DMH, Deputy Director		
<b>Project Managers:</b>		
Cynthia McCoy-Miller, DCFS Kimberly Nall, DMH		
<b>Background:</b>		
Ongoing funding to support the goals of the Katie A. Strategic Plan is crucial to the success of the County's efforts to meet the mental health needs of children in the foster care system. The County is currently providing about \$40 million in County General Funds to support the County's response to the Katie A Settlement Agreement and that amount will increase to over \$90 million once the Plan is fully implemented, absent the ability to identify additional federal and State funding through the efforts identified in the legislative project data sheet.		
<b>Project Objective:</b>		<b>Expected Operational Date:</b>
1. To carefully monitor the program expenditures/revenues for the delivery of Katie A. services and to identify any savings from FY 08-09 associated with the incremental rollout of the Katie A. Strategic Plan and direct it to a Provisional Financial Uses (PFU) to offset costs in FY 09-10. 2. To coordinate legislative efforts with proposed budget development to mitigate the County's fiscal liability in FY 10-11 and beyond as program costs exponentially increase as full-year costs are realized when the plan is fully implemented in FY 14-15.	8/1/09  Ongoing	
<b>Expected Outcomes:</b>		
1. To monitor the Katie A. budget closely and in coordination with the legislative advocacy group, and the Plaintiffs' attorneys and Special Master in the State Katie A. case to develop proposals for submission to the State and/or Federal governments to mitigate the County's fiscal liability for implementing the Katie A. court-mandated services. 2. To ensure the delivery of Katie A. services are provided in the most fiscally prudent manner possible.		

<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>
1. Revision of Wraparound/CFT tiered case rate and EPSSDT revenue modified to two-tiered Wrap/CFT model: <ul style="list-style-type: none"> <li>Tier 1, case rate \$4,184/EPSSDT \$2,246 – total slots 1,217</li> <li>Tier 2, case rate \$1,250/EPSSDT \$2,246 – total slots 2,800, of which 2,051 are DCFS generated and 749 are DMH generated Full Service Partnerships (FSPs) – 523 child/226 Transition Age Youth (TAY) slots</li> </ul>	Michael Rauso Angela Shields	2/1/09	Completed
2. Incorporation of Katie A. FY 09-10 costs as outlined in the 10/14/08 Adopted Strategic Plan and Budget.	Brian Mahan David Seidenfeld	3/1/09	Completed
3. Identification of FY 08-09 savings, including Title IV-E Waiver funds that can be redirected to provide services to class members.	Brian Mahan Susan Kerr David Seidenfeld	8/1/09	In progress
4. Identification of priority assignments not yet budgeted in the FY 09-10 Katie A. Strategic Plan Budget.	Adrienne Olson Greg Lecklitner	3/1/09	Completed
5. Appropriation adjustment and associated Board request for a Provisional Financial Uses (PFU) for Katie A. FY 08-09 savings.	Brian Mahan David Seidenfeld	9/1/09	In progress
6. Review of Federal Stimulus Package's Federal Medical Assistance Percentage (FMAP) two-year revenue enhancements to offset service costs to the Katie A. class in conjunction with the probable redirection of Mental Health Services Act (MHSA) monies and its impact on the budget.	Brian Mahan Susan Kerr David Seidenfeld CEO, Inter-Governmental Relations (IGR)	7/1/09 - 8/1/09	In progress
7. Incorporation of any fiscal relief resulting from legislative advocacy workgroup in the development of the FY 10-11 proposed budget	Brian Mahan David Seidenfeld	3/1/10	In progress

**Resources:**

1. FMAP increase to 61.6 percent for the next 27 months will result in the County receiving \$1.60 per non-Federal matching dollar instead of the dollar per dollar match under the existing 50% FMAP. This additional revenue will help offset some of the County General Funds to pay for services to Katie A. class members.
2. Any regulatory, legislative, administrative proposals providing State/Federal relief to reduce the County's net county cost (NCC) for providing mental health services to Katie A. class and potential class members.
3. Title IV-E child welfare reinvestment funds.
4. Any fiscal relief provided by the Special Master in the State Katie A. case.

**Dependencies:**

Mitigation of County NCC for Katie A. related services is dependent on the "Resources" discussed above.

**Customer Benefits:**

To reduce the proportion of County General Funds used to fund the Katie A. Five-Year Strategic Plan, which when fully implemented in FY 14-15, is anticipated to have a total cost of \$119.9 million.

**Issues and Risks:**

National/State/County budget crises will make it difficult to augment funding for Katie A. service delivery; however, with the Obama administration more progressive policies could be forthcoming from the Centers for Medicare and Medicaid Services (CMS). The County will continue to work collaboratively with the Katie A. Advisory Panel, Plaintiff's attorney, and newly assigned Special Master in the State case to advance the interests of the County in exploring ways to maximize State/federal funding to support the delivery of intensive, home-based mental health services to Katie A. class members.

**PROJECT TEAM MEMBERS**

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<b>PROJECT DATA SHEET</b>							
<b>Project Name:</b> #14- Caseload Reduction							
<b>Start Date:</b> May 2008	<b>Updated:</b> March 2, 2009						
<b>Sponsors:</b>							
Ted Myers, DCFS, Chief Deputy Director, Dick SantaCruz, DCFS							
<b>Project Managers:</b>							
Ted Myers, DCFS Dick SantaCruz, DCFS							
<b>Background:</b>	<p>The ability to provide quality services to clients is directly impacted by the size of the caseload and workload of social work staff. DCFS has committed to lowering caseloads on several fronts. Focus will be placed on the Child Protection Hot Line (CPHL) to safety reduce the volume of calls "screened-in" for investigation and reducing of the number of referrals that require a response within 24 hours (i.e. Immediate Response). Additionally, the Department will move towards providing up-front assessments for after-hour clients that are served by the Emergency Response Command Post (ERCP) staff. Additionally, efforts will be made to reduce the total number of cases by expediting timelines to permanency and adoptions.</p>						
<b>Project Objective:</b>	<b>Expected Operational Date:</b>						
1. Reduce front-end referral rates and case openings.	6/1/09						
2. Increase permanency practice.	6/1/09						
3. Increase or improve human resource practice and rates.	6/1/09						
<b>Expected Outcomes:</b>							
1. Reduction of Emergency Response (ER) caseload average to twenty-two (22) by 6/1/09, eighteen (18) by 6/1/10, fourteen (14) by 6/1/11.							
2. Reduction of Generic caseload average to twenty-four (24) by 6/1/09, twenty (20) by 6/1/10, fifteen (15) by 6/1/11.							
<b>Deliverables:</b>							
1. Hotline – reduce Screen-In rate from 88% to 70 %.	<table border="1"> <thead> <tr> <th><b>Project Lead(s):</b></th><th><b>Planned Timeline:</b></th><th><b>Status</b></th></tr> </thead> <tbody> <tr> <td>Cleo Robinson</td><td>6/1/09</td><td>As of 2/1/09, Screen-in rate has</td></tr> </tbody> </table>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>	Cleo Robinson	6/1/09	As of 2/1/09, Screen-in rate has
<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>					
Cleo Robinson	6/1/09	As of 2/1/09, Screen-in rate has					

Reduce Immediate Response (IR) referrals from 52% to 30%.			dropped to 79.2% about 8.8% improvement. The IR rate has dropped to 37.6% about 14.4% improvement.
2. ERCP – implement Upfront Assessments for clients after-hours.	Ed Sosa	3/1/09	Contract approved on 2/2/09 to fund up-front assessments county-wide.
3. Adoptions – increase % of children adopted within 24 months to 30%.	Bill Thomas	6/1/09	As of 1/2/09 the percentage of children being adopted with 24 months has increased by .2%
4. KinGap – increase number of children in Kingap by 6%.	Michael Gray	6/1/09	New KinGap tracking report developed to allow each office to track progress towards their goal. As of 2/1/09 we have moved 573 youth into KinGap, which is 65% of our goal of 878.
5. Reduce number of Permanent Placement (PP) children by 10% from 5/1/08.	Mercedes Lopez	6/1/09	Goal was to reduce PP caseloads by 10% to 13,395. As of 1/1/09, PP caseloads = 13,485.
6. Reduce Generic caseload average from 26 to 24 cases.		6/1/09	As of 1/2/09 the goal was exceeded. The average = 23.19 cases.
7. Reduce ER caseload average from 24 to 22 referrals.		6/1/09	As of 1/2/09 the goal was exceeded. The average = 18.99 referral children.
8. Human Resources (HR) – hire 160 CSWs by 12/1/08. Maintain hiring of line staff to fill behind attrition rate.	Wanda Hazel	6/1/09	From 6/1/08 – 12/1/08: 289 CSWs were hired. As of 2/1/8, CSW vacancy is 3%.

**Resources:**

1. Hiring of social workers has continued and HR is keeping the staffing level at an all time high.
2. Training resources for the CPHL are adequate.

3. Upfront assessment contracts approved by the Board of Supervisors on 2/2/09.
4. Various online, web-based reports are now available to managers for tracking caseload distribution within each office, KinGap progress, and caseload averages.

**Dependencies:**

1. Reduction of CPHL screen-in rates and IR rates is critical to reducing ER and Generic caseloads. Progress has not been adequate to realize significant drops in ER caseloads
2. The implementation of up-front assessment contracts is an important aspect of ERCP detention reduction strategy.
3. The ability to continue to fill behind vacant CSW positions is critical to overall success in reaching goals.

**Customer Benefits:**

1. The lowering of caseloads will provide CSW staff more time to provide services in the front end.
2. The successful efforts by HR to maintain a high level of CSW staffing has contributed to the progress in caseload reduction.
3. Clients will receive timely assessments due to the recent approval of up-front assessment contracts.

**Issues and Risks:**

1. Contracts for upfront assessments approved on 2/2/09, however this does not allow sufficient time for full implementation by 6/1/09. Though it is unclear if access to up-front assessments will reduce ERCP detentions, clients will benefit from faster access to DMH services.
2. Any freeze on CSW hiring will be detrimental to continued progress in caseload reduction.
3. The effects of the dramatic economic downturn, coupled with the State's budget instability and recent freeze of child welfare payments, may result in increased child abuse and referrals to the CPHL.
4. Decreased or unavailable Temporary Aid to Needy Families (TANF) payments to vulnerable populations, including single parent families, may contribute to increased risk to children.

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<b>PROJECT DATA SHEET</b>	
<b>Project Name:</b> #15- Legislative Advocacy	
<b>Start Date:</b> November 1, 2008	
<b>Sponsors:</b>	
Miguel Santana, CEO Trish Ploehn, DCFS Mary Southard, DMH Sheila Shima, DMH	
<b>Project Managers:</b>	
Susan Rajjal, DMH Mitch Mason, DCFS Lesley Blacher, CEO	
<b>Background:</b>	<p>The Katie A. Strategic Plan Board Letter and Strategic Plan, approved by the Board of Supervisors on October 14, 2008, directed the Chief Executive Office (CEO) along with the Departments of Children and Family Services (DCFS) and Mental Health (DMH) to develop legislative, regulatory, and administrative proposals seeking greater flexibility from the State to maximize revenue reimbursement to the County, particularly in claiming Medi-Cal Early Periodic Screening, Diagnosis and Treatment (EPSDT) funds.</p>
<b>Project Objective:</b>	<b>Expected Operational Date:</b>
1. Incorporate Katie A. into the County's FY 2009-10 Legislative Platform. 2. Educate legislators on the importance of preserving Mental Health Service Act (MHSA) funds and in discussing some of the shortfalls/nuances of EPSDT funding. 3. Examine what cost efficiencies/cost neutral activities other jurisdictions have put into place with Medi-Cal funding.	11/1/08 2/1/09 – ongoing In progress
<b>Expected Outcomes:</b>	<ol style="list-style-type: none"> <li>1. Have a clearer understanding of Medi-Cal service eligibility and reimbursement guidelines for the provision of integrated mental health services in social service delivery models such as Wraparound.</li> <li>2. Put proposals in place for State/Federal consideration to reduce the County's net county cost (NCC) for providing mental health services to Katie A. class and potential class members.</li> </ol>

<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>
1. Develop fact sheets for upcoming meetings with legislators to: <ul style="list-style-type: none"> <li>• Educate legislators on the importance of preserving Mental Health Service Act (MHSA) funds incorporating LA County outcomes resulting from MHSA funding; and</li> <li>• Stress the importance for the State to clearly articulate EPSDT billable from Wraparound integrated service activities within the Wraparound integrated service model.</li> </ul>	Susan Rajal Greg Lecklitner	2/4/09	Completed
2. Develop analysis determining whether a State Plan Amendment is required to increase the billing rate for DMH co-located staff/mental health providers beyond the capped State schedule of maximum allowances (SMA). Providers can provide Wraparound services and be adequately reimbursed for costs incurred (at a higher rate) to compensate for those activities that are not billable, i.e. completion of court reports.	Anita Lee	2/19/08	Completed
3. Develop Proposal for CMS inclusive of recommended enhanced rate structure for Wraparound Services, based on cost data collected for a period, along with developing regulations, which define eligibility criteria for receiving a higher reimbursement rate for Wraparound services. An earlier version of this proposal to be shared with the Special Master in the Katie A. State Case.	Anita Lee	3/31/10	In progress
4. Disaggregate non-billable from non-reimbursable service costs from the Wraparound Mental Health Service Activity Claiming Matrix to clearly delineate service activities that are not covered by Medi-Cal	Norma Fritsche	3/27/09	In progress

<b>Resources:</b>	There is existing staff.	
<b>Dependencies:</b>	<ul style="list-style-type: none"> <li>1. State budget cuts and revenue redirection, i.e. Proposition 63 MHSAs funds; and</li> <li>2. Impact of the Obama administration on the Centers for Medicare and Medicaid Services (CMS).</li> </ul>	
<b>Customer Benefits:</b>	<ul style="list-style-type: none"> <li>1. A clearer understanding for counties concerning the State's position on Medi-Cal service eligibility and reimbursement for integrated/intensive mental health service provisions through service delivery models such as Wraparound.</li> </ul>	
<b>Issues and Risks:</b>	<ul style="list-style-type: none"> <li>1. National/State budget crises will make it difficult to augment Medi-Cal funding; however, with the Obama administration, more progressive policies could be forthcoming from CMS.</li> <li>2. The County will continue to work collaboratively with the Katie A. Advisory Panel and Plaintiffs' attorney in the State case to advance the interests of the County in exploring ways to maximize federal funding for Wraparound-like services and seeking ways to make the provision of such services easier for counties within existing Medi-Cal requirements to draw down.</li> </ul>	
<b>PROJECT TEAM MEMBERS</b>		
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<b>PROJECT DATA SHEET</b>	
<b>Project Name:</b> #16- Training	
<b>Start Date:</b> January 1, 2009	
<b>Sponsors:</b>	
Susan Kerr, DCFS, Senior Deputy Director Olivia Celis, DMH, Deputy Director	
<b>Project Managers:</b>	
Mark Miller, DCFS Angela Shields, DMH	
<b>Background:</b>	<p>Consistent with the November 2006 order of the federal court and in concurrence with the Katie A. Advisory Panel, Los Angeles County has recognized the need for systemic improvements to better meet the mental health needs of children and families. To ensure identification of DCFS children's needs and that individualized, intensive home-based services are delivered, DCFS and DMH will jointly deploy training support and resources based upon the foundations of good practice – engaging families, effective teaming and coordination, thorough assessment of strengths and needs, individualized planning and effective interventions. Targeted training and learning objectives will support the implementation of screening and assessment protocols and the plan for a strengthened service delivery system.</p>
<b>Project Objectives:</b>	<b>Expected Operational Date:</b>
1. Joint Overview/Orientation Training (Core Practice Model, Values, Practice Principles, etc.)	3/17/09 – 4/29/08 – Belvedere/SFS 5/1/09 – Wateridge/Vermont 6/1/09 - Compton 7/1/09 - Palmdale/Lancaster
2. Training to Support Targeted Strategies for Resource Development and Process Change	In progress
3. Training to Support DMH / DCFS Specialized Functions	In progress
4. Training and Coaching to Support Implementation of Child and Family Teams (provider and public agency staff)	In progress
5. SABA Learning Management System (LMS)	In progress

### **Expected Outcomes:**

<ol style="list-style-type: none"> <li>1. Joint Overview/Orientation: Strengthened understanding, alignment and shared ownership/accountability (DMH/DCFSS) with regard to key Katie A. components and initiatives at local level. Better understanding, integration and application of skills associated with the Core Practice Model/QSR supporting successful implementation and ongoing improvement.</li> <li>2. Training to support targeted strategies:                     <ul style="list-style-type: none"> <li>• Training supports the expansion and application of Team Decision-Making (TDM).</li> <li>• Training on Structured Decision Making (SDM) supports improved decision making at key decision points including the Child Protection Hotline to meet caseload reduction targets in DCFSS.</li> <li>• Training to support implementation and expansion of Up-Front Assessments and the expansion of Multi-disciplinary Assessment Teams (MAT) for the timely assessment and linkage to service for referred children and families.</li> <li>• Training on key initiatives (Concurrent Planning, Permanency Partners Program, Family Finding/Engagement) to advance implementation of targeted strategies for improving timelines to permanency.</li> </ul> </li> <li>3. Training to support DMH / DCFSS specialized functions, such as Katie A. Screening and Assessment components and infrastructure to insure prompt screening, assessment and linkage to key services. Supports CSAT, RMP, Mental Health Screening Tool, Referral Tracking System and other related policies and protocols.</li> <li>4. Training and Coaching to support implementation of Child and Family Teams to support expansion of the provider base that delivers a Wraparound approach to Child and Family Teams and Intensive in-home based services.</li> <li>5. Training supports practice change for line staff based on Core Practice Model/QSR; supported through coaching/mentoring model for skill application/development.</li> <li>6. SABA Learning Management System (LMS) will streamline the attendance, feedback and tracking process for employee training.</li> </ol>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;"><b>Deliverables:</b></th><th style="text-align: center;"><b>Project Lead(s):</b></th><th style="text-align: center;"><b>Planned Timeline:</b></th><th style="text-align: center;"><b>Status</b></th></tr> </thead> <tbody> <tr> <td>1. Develop and provide joint overview/orientation training - DMH, DCFSS, providers</td><td>Mark Miller Angela Shields</td><td>3/1/09</td><td>In progress - 8 regional office visits completed</td></tr> <tr> <td>2. Provide training to support targeted strategies – TDM, SDM, Concurrent Planning Re-Design, Visitation</td><td>Mark Miller Angela Shields Inter-University Consortium (IUC)</td><td>On-going</td><td>In progress Training is on-going to maximize caseload reduction efforts</td></tr> <tr> <td>3. Provide training to support Katie A. Plan components – CSAT, RMP, CANS, Consent, CFT, Referral Tracking</td><td>Mark Miller Angela Shields David Cantu</td><td>3/1/09</td><td>In progress</td></tr> </tbody> </table>	<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>	1. Develop and provide joint overview/orientation training - DMH, DCFSS, providers	Mark Miller Angela Shields	3/1/09	In progress - 8 regional office visits completed	2. Provide training to support targeted strategies – TDM, SDM, Concurrent Planning Re-Design, Visitation	Mark Miller Angela Shields Inter-University Consortium (IUC)	On-going	In progress Training is on-going to maximize caseload reduction efforts	3. Provide training to support Katie A. Plan components – CSAT, RMP, CANS, Consent, CFT, Referral Tracking	Mark Miller Angela Shields David Cantu	3/1/09	In progress
<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>														
1. Develop and provide joint overview/orientation training - DMH, DCFSS, providers	Mark Miller Angela Shields	3/1/09	In progress - 8 regional office visits completed														
2. Provide training to support targeted strategies – TDM, SDM, Concurrent Planning Re-Design, Visitation	Mark Miller Angela Shields Inter-University Consortium (IUC)	On-going	In progress Training is on-going to maximize caseload reduction efforts														
3. Provide training to support Katie A. Plan components – CSAT, RMP, CANS, Consent, CFT, Referral Tracking	Mark Miller Angela Shields David Cantu	3/1/09	In progress														

4. CFT/Wraparound training overview – public agency staff	IUC Sherman Mikle	4/1/09	In progress Curriculum under development
5. Core practice model/QSR in-depth practice training – public agency staff	IUC Mark Miller	5/1/09	In progress Curriculum under development
6. Implementing CFT through coaching and mentoring – provider staff	Sherman Mikle Shirley Robertson Angela Shields	5/1/09	In progress Contracts under development
7. SABA - Learning Management Systems (LMS)	Mark Miller Angela Shields	1/2/09	In progress
<b>Customer Benefits:</b>			
1. DCFS and DMH staff will have a better understanding of the various initiatives relating to the Katie A. Settlement Agreement. 2. Public agency staff will have obtained the requisite skills to effectively implement the four primary provisions of Wrap: engagement/team preparation, initial plan development, implementation, and transition. 3. Provider staff will have on-going support in the implementation and expansion of Child and Family Teams through coaching and mentoring.			
<b>Resources:</b>			
1. Eight (8) CSA I's to provide direct training, planning, coordination, and delivery of training. 2. One (1) CSA II to provide operational oversight to the CSA I trainers; one (1) STC to provide clerical support. 3. The annual budget for training related purposes is approximately \$1 million per year.			
<b>Dependencies:</b>			
1. Overview training relies upon the completion/finalization of the respective policies. 2. Procurement of consultants and hiring key staff will affect the deliverables. 3. Trainings based upon expansion time-frames and staff hiring for Wraparound providers.			
<b>Issues and Risks:</b>			
1. On-going participation by line-staff (DCFS/DMH) in the development of curriculum is essential to securing shared ownership of the plan. 2. Challenge of balancing multi-day skill-based training for line case carrying staff against demands of ongoing casework.			

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<b>PROJECT DATA SHEET</b>	
<b>Project Name:</b> #17- Data Management	
<b>Start Date:</b> September 2008	
<b>Sponsors:</b>	
Olivia Celis-Karim, DMH, Deputy Director Charles Sophy, DCFS, Medical Director	
<b>Project Managers:</b>	
Elaine Magnante-Music, DCFS Gary Puckett, DMH Ayanna McLeod, CEO	
<b>Background:</b>	<p>In response to the Katie A. Settlement Agreement, the County of Los Angeles, in concurrence with the Katie A. Panel, agreed to select and track a discrete set of data indicators for all class members to determine whether children are being systematically screened and assessed for mental health needs and, when appropriately identified, receive those services in a timely manner. In addition, data indicators that track safety, permanency, well-being, and mental health service expenditures monitored to evaluate Katie A. program implementation.</p>
<b>Project Objective:</b>	<p>1. Identify data indicators to measure and monitor progress in the following:</p> <ul style="list-style-type: none"> <li>• Timeliness of Mental Health Screenings;</li> <li>• Assessment;</li> <li>• Referral to Service;</li> <li>• Provision of Treatment;</li> <li>• Duration of Service;</li> <li>• Mental Health Expenditures, and</li> <li>• Outcomes associated with the delivery of service – safety, permanency, and well-being.</li> </ul> <p>2. Confirm selection of subset of Operational Efficiency, Safety, Permanency, Well-Being, and Mental Health Expenditure indicators and the development of benchmarks, operational definitions, and tracking intervals for exit criteria.</p>
<b>Expected Operational Date:</b>	<p>In progress</p> <p>In progress</p>

**Expected Outcomes:**

1. Development of a discrete set of data indicators that will monitor accountability and compliance with the terms of the Settlement Agreement.
2. Provide a means for evaluating the timeliness of children screened, assessed and linked to mental health services as needed.

<b>Deliverables:</b>	<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>
1. Development of Katie A. “Draft” Data Inventory	Ayanna McLeod	3/1/08	Completed
2. Finalize selection of data indicators and those identified as “Exit Condition” data indicators (see attached Data Inventory)	All	3/25/09	Completed
3. Finalize data descriptions and operationalize data definitions	Jennifer Eberle Norma Fritzsche Cecilia Custodio Alan Weisbart	3/18/09	Completed
4. Build Referral Tracking System (RTS) to gather data	See PDS for RTS	See PDS for RTS	See PDS for RTS
<b>Resources:</b>	<p>1. Chief Information Office Bureau has hired 2 staff positions to support the data project and CEO and DHR are providing additional support to expedite the hiring of the 3<sup>rd</sup> position.</p> <p>2. DCFS has hired one (1) of five (5) Information Technology positions allocated through the Katie A. Strategic Plan and is aggressively advertising to fill the remaining positions.</p> <p>3. Approximately \$500,000 is allocated to hire consultants to act as Project Manager, Business Analyst and Application Developer over the DMH administered Katie A. database and associated cubes.</p>		
<b>Dependencies:</b>	<p>1. DCFS will need to flag “Special Project” fields within CWS/CMS in the interim to track mental health services delivery.</p> <p>2. DMH and DCFS to provide each other with data elements necessary for the incorporation into the Cognos Cube and CWS/CMS; which will assist in the tracking and monitoring of mental health service delivery and client level outcomes.</p> <p>3. Hiring of key staff/expediting the procurement process for the consultants will affect the deliverables.</p>		
<b>Customer Benefits:</b>	<p>1. Capacity to monitor and evaluate the timeliness and efficacy of mental health screening, assessment and service delivery, as well as programmatic outcomes related to the Katie A. Strategic Plan.</p>		

**Issues and Risks:**

1. SACWIS regulations and mental health/child welfare confidentiality provisions continue to remain an obstacle in data sharing between the departments of DCFS and DMH. When the federal court order directing the departments to share data expires, new agreement directives will need to be put in place to continue the sharing of this data between the two departments for planning and service coordination functions.

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## KATIE A. DATA INVENTORY

**03/12/2009**

### Issues To Be Determined:

- Data Measurement – point in time versus proxy class/entry cohort
- Operational definition for proxy class/entry cohort (timeframe to track calendar year versus fiscal year)
- Confirmation of selection of Operational Efficiency Indicators for Exit Criteria and development of benchmarks
- Selection of subset of Safety, Permanency, Well-Being, and Mental Health Service Expenditure Indicators to track as part of Exit Criteria; operational definitions; baselines/standards
- Selection of subset of informational indicators to track and standards
- Determination of which indicators should be tracked longitudinally and should any distinctions be made between variables capturing rates versus time-lags
- Determine tracking intervals for variables (both Exit and Informational)

### DEMOGRAPHICS

	Data Indicator	Category	Tracking Intervals	Data Source	Data Indicator Description
1	Total number of active cases in DCFS	7		CWS/CMS	Includes voluntary, involuntary, in-home and out-of-home placements.
2	By Regional Office/SPA (number/percentage/total)	7		CWS/CMS	Refers to DCFS office with current case responsibility.
3	By placement type (number/percentage/total)	7		CWS/CMS	
4	By service component	7		CWS/CMS	FM, FR, PP
5	By case status	7		CWS/CMS	Voluntary vs. Court Cases
6	By rate classification level	7		CWS/CMS	
7	By age category	7		CWS/CMS	
8	By race/ethnicity	7		CWS/CMS	(need to define race)
9	By language spoken (child and family)	7		CWS/CMS	
10	By gender	7		CWS/CMS	
11	By placement location – by SPA	7		CWS/CMS	

## OPERATIONAL EFFICIENCY – NEWLY DETAINED (ND)

	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/ National Standard	Context: (E)xit or (I)nfo	Data Indicator Description
1	Have newly detained (ND) children been screened within 30 days of case opening?			CWS/ CMS (SP)	✓	E	Newly detained children from new referrals converted into a case under a WIC 300 petition filing and placed out of home.
1a.	Date of initial case plan	7		CWS/ CMS		I	Use date Program Code change from ER to FR - Information currently exists in CWS/CMS.
1b.	Date of referral to HUB			CWS/ CMS (SP)			DCFS has created a Special Projects field in CWS/CMS to track date of referral to the HUB
1c.	CIMH mental health screening (positive/negative) and date	7		CWS/ CMS (SP)		I	DCFS has created Special Projects fields in CWS/CMS to track all CIMH/MHST positive and negative screens
1d.	Number/percent of ND children receiving positive/negative mental health screening	7		CWS/ CMS (SP)		I	DCFS has created Special Projects fields in CWS/CMS to track all CIMH/MHST positive and negative screens
1e.	DCFS Consent for Mental Health Services provided (parent, court, child, denied) and date	7		CWS/ CMS (SP)		I	DCFS has created a Special Projects field in CWS/CMS to track date consent was received from parent, court, child or denied
1f.	Number/percent of ND children for whom Consent for Services is provided	7		CWS/ CMS (SP)		I	To be calculated from DCFS data input into Cognos Cube – DCFS has created a Special Projects field in CWS/CMS to track date consent was received
1g.	Date of EPSDT eligibility	7		CWS/ CMS (SP)		I	DCFS has created a Special Projects field in CWS/CMS to track “Medi-Cal Eligible” and the date that eligibility is established.
1h.	Number/percent of EPSDT eligible children who screen positive for mental health services (active full-scope Medi-Cal)	7		CWS/ CMS (SP)		I	To be calculated from DCFS data input into Cognos Cube using DCFS CIMH screen date and DCFS Benefits Establishment
1i.	Number/percent of ND children who screen positive for mental health services who are not EPSDT eligible (not active full-scope Medi-Cal)	7		CWS/ CMS (SP)		I	To be calculated from DCFS CIMH positive screen and Non-Medi-Cal eligible Special Project fields in CWS/CMS
2	Do ND children who screen positive for mental health issues receive timely mental health services?			DMH Data Warehouse	✓	E	Bullets below answer this question

## OPERATIONAL EFFICIENCY – NEWLY DETAINED (ND)

	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/National Standard	Context: (E)xit or (I)nfo	Data Indicator Description
2a.	Number of days between positive screening and referral to DMH	7		CWS/CMS (SP)			DCFS has created a Special Projects field in CWS/CMS to track date of positive screening and date of referral to DMH
2b.	Number of days between positive mental health screening and case opening	7		DMH Data Warehouse	✓	E	CIMH positive screen date from Special Projects in CWS/CMS and date a DMH episode was opened for all children in Cognos Cube
2c.	Number of days between positive mental health screening and face-to-face assessment contact			DMH Data Warehouse			CIMH positive screen date from Special Projects in CWS/CMS and date of first 90801 or 90802
2d.	Number of days between case opening and the start of a face to face contact for mental health assessment	7		DMH Data Warehouse			
2e.	Number/percent of ND children receiving a mental health assessment	7		DMH Data Warehouse		1	Number of kids having a 90801/90802 and compare to total DCFS population
3	Number/percent of ND children eligible for mental health services due to presence of medical necessity (included diagnosis)	7		DMH Data Warehouse		1	Clients diagnosed with an “included” diagnosis meet medical necessity; compare diagnosis in Cognos Cube with list of included diagnoses; each time data is pulled, pull current diagnosis to pick up changes that may have been made since last data draw.
4	Do those ND children determined eligible for mental health services (i.e. have an included diagnosis) receive mental health treatment in a timely manner?			DMH Data Warehouse	✓	E	Bullets below answer this question
4a.	Number of days between positive CIMH/MHST screening and initial mental health treatment delivery	7		DMH Data Warehouse		1	Date positive DCFS screening and date of an initial service code (therapy, rehab, group)
4b.	Number of days between DMH open episode date and initial mental health treatment delivery	7		DMH Data Warehouse		1	Date of DMH episode opening and date of an initial service code
4c.	Number of days between face to face assessment contact and initial mental health treatment delivery	7		DMH Data Warehouse		1	Date of first 90801/90802 and date of an initial service code

## OPERATIONAL EFFICIENCY – NEWLY DETAINED (ND)

	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/National Standard	Context: (Exit or ()info	Data Indicator Description
4d.	Unique Number/percent of ND children receiving intensive mental health services	7		DMH Data Warehouse		1	Number of children enrolled in FSP, SOC, ITFC and Intensive In-Home which includes: MST, MTFC, CCSP, and Wraparound plans
4e.	Number of days between intensive mental health services start and end date: by termination reason	7		DMH Data Warehouse		1	First date of claim and episode closure for kids in FSP, SOC, MST, MTFC, CCSP, Intensive In-Home and Wraparound plans; referral out codes could provide data for termination
4f.	Unique Number/percent of ND children receiving basic mental health services	7		DMH Data Warehouse		1	Number of children without claims in FSP, SOC, MST, MTFC, CCSP, Intensive In-Home and Wraparound plans for 30 days
4g.	Number of days between basic mental health services start and end date: by termination reason	7		DMH Data Warehouse		1	First date of claim and episode closure as long as the claim is not in one of the above intensive plans; referral out codes could provide data for termination

## OPERATIONAL EFFICIENCY – NEWLY DETAINED/MAT (ND-MAT)

	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/National Standard	Context: (Exit or ()info	Data Indicator Description
2	Do ND-MAT children who screen positive for mental health issues receive timely mental health services?			DMH Data Warehouse	✓	E	Bullets below answer this question
2a.	Number of days between positive mental health screening and referral to DMH for MAT assessment			CWS/ CMS (SP)			DCFS has created a Special Projects field in CWS/CMS to track date of positive screening and date of referral to DMH (MAT/Co-located) Cube
2b.	Number of days between positive mental health screening and MAT case opening			DMH Data Warehouse			CIMH positive screen date from Special Projects in CWS/CMS and date a DMH episode was opened for all children in Cognos Cube
2c.	Number of days between positive mental health screening and MAT face-to-face assessment contact			DMH Data Warehouse			CIMH positive screen date from Special Projects in CWS/CMS and date of first 90801 or 90802

## OPERATIONAL EFFICIENCY – NEWLY DETAINED/MAT (ND-MAT)

	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark National Standard	Context: (Exit or ()Info	Data Indicator Description
2d.	Number of days between MAT case opening and the start of a face to face contact for mental health assessment	7		DMH Data Warehouse	-		Date of first claim to MAT plan (i.e. opening of MAT services) and date of the first 90801 (psychiatric diagnostic interview) or 90802 (interactive psychiatric diagnostic interview) using play equipment, physical devices, or other non-verbal mechanism of communication) procedure codes for clients using the MAT-DMH Plan
2e.	Number/percent of ND-MAT children receiving a mental health assessment	7		DMH Data Warehouse	-		Number of kids having a 90801/90802 and compare to total DCFS population
3	Number/percent of ND-MAT children eligible for mental health services due to presence of medical necessity (included diagnosis)	7		DMH Data Warehouse	-		Clients diagnosed with an “included” diagnosis meet medical necessity; compare diagnosis in Cognos Cube with list of included diagnoses; each time data is pulled, pull current diagnosis to pick up changes that may have been made since last data draw.
4	Do those ND-MAT children determined eligible for mental health services (i.e. have an included diagnosis) receive mental health treatment in a timely manner?	7		DMH Data Warehouse	✓	E	Bullets below answer this question
4a.	Number of days between date of positive CIMH/MHST screening and initial mental health treatment delivery for MAT cases	7		DMH Data Warehouse	-		Date of first 90801 and date of a initial service code (therapy, rehab, group)
4b.	Number of days between opening of a MAT DMH episode date and initial mental health treatment delivery			DMH Data Warehouse	-		Date of DMH MAT episode opening and date of an initial service code
4c.	Number of days between MAT face to face assessment contact and initial mental health treatment delivery			DMH Data Warehouse	-		Date of first 90801/90802 and date of an initial service code

## OPERATIONAL EFFICIENCY – NEWLY OPENED/NON-DETAINED (NOD)

	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark National Standard	Context: (E)xit or (I)nto	Data Indicator Description
1	Have newly opened/non-detained (NOD) children been screened within 30 days of case opening?	7		CWS/ CMS (SP)	✓	E	Newly Opened/Non-detained = Children from new referrals converted into a case under a Voluntary Family Maintenance (VFM), Voluntary Family Reunification (VFR), or court-ordered Family Maintenance (FM) case plan.
1a.	Date of initial case plan	7		CWS/ CMS		I	Use date Program Code change from ER to FM - Information currently exists in CWS/CMS.
1b.	CIMH mental health screening (positive/negative) and date	7		CWS/ CMS (SP)		I	DCFS has created Special Projects fields in CWS/CMS to track all CIMH/MHST positive and negative screens
1c.	Number/percent of NOD children receiving positive/negative mental health screening	7		CWS/ CMS (SP)		I	DCFS has created Special Projects fields in CWS/CMS to track all CIMH/MHST positive and negative screens
1d.	DCFS Consent for Mental Health Services provided (parent, court, child, denied) and date	7		CWS/ CMS (SP)		I	DCFS has created a Special Projects field in CWS/CMS to track date consent was received from parent, court, child or denied
1e.	Number/percent of NOD children for whom Consent for Services is provided	7		CWS/ CMS (SP)		I	To be calculated from DCFS data input into Cognos Cube – DCFS has created a Special Projects field in CWS/CMS to track date consent was received
1f.	Date of EPSDT eligibility	7		CWS/ CMS (SP)		I	DCFS has created a Special Projects field in CWS/CMS to track “Medi-Cal Eligible” and the date that eligibility is established.
1g.	Number/percent of NOD children who screen positive for mental health services who are EPSDT eligible (active full-scope Medi-Cal)	7		CWS/ CMS (SP)		I	To be calculated from DCFS data input into Cognos Cube using DCFS CIMH screen date and DCFS Benefits Establishment
1h.	Number/percent of NOD children who screen positive for mental health services who are not EPSDT eligible (no active full-scope Medi-Cal)	7		CWS/ CMS (SP)		I	To be calculated from DCFS CIMH positive screen and Non-Medi-Cal eligible Special Project fields in CWS/CMS
2	Do NOD children who screen positive for mental health issues receive timely mental health services?			DMH Data Warehouse	✓	E	Bullets below answer this question

## OPERATIONAL EFFICIENCY – NEWLY OPENED/NON-DETAINED (NOD)

	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/National Standard	Context: (E)xit or (I)info	Data Indicator Description
2a.	Number of days between positive screening and referral to DMH for assessment	7		CWS/CMS (SP)			DCFS has created a Special Projects field in CWS/CMS to track date of positive screening and date of referral to DMH (Co-located)
2b.	Number of days between positive mental health screening and case opening	7		DMH Data Warehouse	✓	E	CIMH positive screen date from Special Projects in CWS/CMS and date a DMH episode was opened for all children in Cognos Cube
2c.	Number of days between positive mental health screening and face-to-face assessment contact			DMH Data Warehouse			CIMH positive screen date from Special Projects in CWS/CMS and date of first 90801 or 90802
2d.	Number of days between case opening and the start of a face to face contact for mental health assessment			DMH Data Warehouse			
2e.	Number/percent of NOD children receiving a mental health assessment	7		DMH Data Warehouse		1	Number of kids having a 90801/90802 and compare to total DCFS population
3	Number/percent of NOD children eligible for mental health services due to presence of medical necessity (included diagnosis)	7		DMH Data Warehouse		1	Clients diagnosed with an "included" diagnosis meet medical necessity; compare diagnosis in Cognos Cube with list of included diagnoses; each time data is pulled, pull current diagnosis to pick up changes that may have been made since last data draw.
4	Do those NOD children determined eligible for mental health services (i.e. have an included diagnosis) receive mental health treatment in a timely manner?	7		DMH Data Warehouse	✓	E	Bullets below answer this question
4a.	Number of days between positive CIMH/MHST screening and initial mental health treatment delivery	7		DMH Data Warehouse		1	Date positive DCFS screening and date of an initial service code (therapy, rehab, group)
4b.	Number of days between DMH open episode date and initial mental health treatment delivery	7		DMH Data Warehouse		1	Date of DMH episode opening and date of an initial service code

## OPERATIONAL EFFICIENCY – NEWLY OPENED/NON-DETAINED (NOD)

	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/ National Standard	Context: (E)xit or (I)nfo	Data Indicator Description
4c.	Number of days between face to face assessment contact and initial mental health treatment delivery	7		DMH Data Warehouse		1	Date of first 90801/90802 and date of an initial service code
4d.	Unique Number/percent of NOD children receiving intensive mental health services	7		DMH Data Warehouse		1	Number of children enrolled in FSP, SOC, ITFC and Intensive In-Home which includes: MST, MTFC, CCSP, and Wraparound plans
4e.	Number of days between intensive mental health services start and end date: by termination reason			DMH Data Warehouse		1	First date of claim and episode closure for kids in FSP, SOC, MST, MTFC, ITFC, CCSP, Intensive In-Home and Wraparound plans; referral out codes could provide data for termination
4f.	Unique Number/percent of NOD children receiving basic mental health services	7		DMH Data Warehouse		1	Number of children without claims in FSP, SOC, MST, MTFC, ITFC, CCSP, Intensive In-Home and Wraparound plans for 30 days
4g.	Number of days between basic mental health services start and end date: by termination reason	7		DMH Data Warehouse		1	First date of claim and episode closure as long as the claim is not in one of the above intensive plans; referral out codes could provide data for termination

## OPERATIONAL EFFICIENCY – EXISTING OPEN (EO)

	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/ National Standard	Context: (E)xit or (I)nfo	Data Indicator Description
1	Have existing/open case (EO) children been screened within 30 days of case opening?	7		CWS/ CMS (SP)	✓	E	Existing = Open cases under all court-ordered or Voluntary FM, FR, and PP case plans.
1a.	CIMH mental health screening (positive/negative) and date	7		CWS/ CMS (SP)		1	DCFS has created Special Projects fields in CWS/CMS to track all CIMH/MHST positive and negative screens
1b.	Number/percent of EO children receiving positive/negative mental health screening	7		CWS/ CMS (SP)		1	DCFS has created Special Projects fields in CWS/CMS to track all CIMH/MHST positive and negative screens
1c.	DCFS Consent for Mental Health Services provided (parent, court, child, denied) and date	7		CWS/ CMS (SP)		1	DCFS has created a Special Projects field in CWS/CMS to track date consent was received from parent, court, child or denied

## OPERATIONAL EFFICIENCY – EXISTING OPEN (EO)

	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/National Standard	Context: (E)xit or (I)nfo	Data Indicator Description
1d.	Number/percent of EO children for whom Consent for Services is provided	7		CWS/ CMS (SP)		–	To be calculated from DCFS data input into Cognos Cube – DCFS has created a Special Projects field in CWS/CMS to track date consent was received
1e.	Date of EPSDT eligibility	7		CWS/ CMS (SP)		–	DCFS has created a Special Projects field in CWS/CMS to track “Medi-Cal Eligible” and the date that eligibility is established.
1f.	Number/percent of EPSDT eligible EO children who screen positive for mental health services (active full-scope Medi-Cal)	7		CWS/ CMS (SP)		–	To be calculated from DCFS data input into Cognos Cube using DCFS CIMH screen date and DCFS Benefits Establishment
1g.	Number/percent of EO children who screen positive for mental health services who are not EPSDT eligible (not active full-scope Medi-Cal)	7		CWS/ CMS (SP)		–	To be calculated from DCFS CIMH positive screen and Non-Medi-Cal eligible Special Project fields in CWS/CMS
2	Do EO children who screen positive for mental health issues receive timely mental health services?			DMH Data Warehouse	✓	E	Bullets below answer this question
2a.	Number of days between positive screening and referral to DMH for assessment	7		CWS/ CMS (SP)			DCFS has created a Special Projects field in CWS/CMS to track date of positive screening and date of referral to DMH (Co-located)
2b.	Number of days between positive mental health screening and case opening	7		DMH Data Warehouse	✓	E	CIMH positive screen date from Special Projects in CWS/CMS and date a DMH episode was opened for all children in Cognos Cube
2c.	Number of days between positive mental health screening and face-to-face assessment contact			DMH Data Warehouse			CIMH positive screen date from Special Projects in CWS/CMS and date of first 90801 or 90802
2d.	Number of days between case opening and the start of a face to face contact for mental health assessment	7		DMH Data Warehouse			

## OPERATIONAL EFFICIENCY – EXISTING OPEN (EO)

	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/National Standard	Context: (E)xit or (I)nfo	Data Indicator Description
2e.	Number/percent of EO children receiving a mental health assessment	7		DMH Data Warehouse		1	Number of kids having a 90801/90802 and compare to total DCFS population
3	Number/percent of EO children eligible for mental health services due to presence of medical necessity (included diagnosis)	7		DMH Data Warehouse		1	Clients diagnosed with an "included" diagnosis meet medical necessity; compare diagnosis in Cognos Cube with list of included diagnoses; each time data is pulled, pull current diagnosis to pick up changes that may have been made since last data draw.
4	Do those EO children determined eligible for mental health services (i.e. have an included diagnosis) receive mental health treatment in a timely manner	7		DMH Data Warehouse	✓	E	Bullets below answer this question
4a.	Number of days between positive CIMH/MHST screening and initial mental health treatment delivery	7		DMH Data Warehouse		1	Date positive DCFS screening and date of an initial service code (therapy, rehab, group)
4b.	Number of days between DMH open episode date and initial mental health treatment delivery	7		DMH Data Warehouse		1	Date of DMH episode opening and date of an initial service code
4c.	Number of days between face to face assessment contact and initial mental health treatment delivery	7		DMH Data Warehouse		1	Date of first 90801/90802 and date of an initial service code
4d.	Unique Number/percent of EO children receiving intensive mental health services	7		DMH Data Warehouse		1	Number of children enrolled in FSP, SOC, ITFC and Intensive In-Home which includes: MST, MTFC, CCS, and Wraparound plans
4e.	Number of days between intensive mental health services start and end date: by termination reason	7		DMH Data Warehouse		1	First date of claim and episode closure for kids in FSP, SOC, MST, MTFC, CCS, Intensive In-Home and Wraparound plans; referral out codes could provide data for termination
4f.	Unique Number/percent of EO children receiving basic mental health services	7		DMH Data Warehouse		1	Number of children without claims in FSP, SOC, MST, MTFC, CCS, Intensive In-Home and Wraparound plans for 30 days

## OPERATIONAL EFFICIENCY – EXISTING OPEN (EO)

	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/National Standard	Context: (E)xit or (I)nfo	Data Indicator Description
4g.	Number of days between basic mental health services start and end date: by termination reason	7		DMH Data Warehouse		1	First date of claim and episode closure as long as the claim is not in one of the above intensive plans; referral out codes could provide data for termination

	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/National Standard	Context: (E)xit or (I)nfo	Data Indicator Description
							<b>SAFETY</b>
1	Percent of referred children by disposition type	P		CWS/CMS		1	<ul style="list-style-type: none"> <li>Includes: Evaluated out, Unfounded, Inconclusive, Substantiated, Not Disposed</li> <li>Excludes referrals with disposition type “entered in error” and with no referral response type.</li> </ul>
2	Percent of open cases that have had 2 or more substantiated referrals during the last 12 months	P		CWS/CMS	DCFS Benchmark - 5.6%	E	<ul style="list-style-type: none"> <li>2 or more referrals on active cases for the last 12 months from the last day of the reporting month</li> <li>Number of active cases is based on active cases on the last day of each reporting month</li> </ul>
3	No maltreatment in foster care – Of all children served in foster care during the year, what percent were not victims of a substantiated maltreatment allegation by a foster parent/facility staff member?	P		CWS/CMS	National standard - 99.58%	E	Percentage of all children served in foster care, were not victims of a substantiated maltreatment allegation by a foster parent or facility staff member.
4	No recurrence of maltreatment within 6 months – after substantiated referral	F		CWS Outcomes Systems Summary – UC Berkeley	National standard - 94.6%	E	Percentage of children who do not experience repeat maltreatment during the 6 month period that followed the initial substantiated abuse report.

SAFETY					
	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/National Standard
					Context: (E)xit or (I)nfo
5	Percent of children enter foster care within 12 months of receiving Family Maintenance (FM) Services	P		CWS/CMS	<ul style="list-style-type: none"> <li>Number of FM children removed is those who were removed from the home of their parents within 12 months of receiving FM services.</li> <li>Number of children for the reporting month is the number of children who received FM services during each of the reporting months.</li> </ul>
PERMANENCY					
	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/National Standard
					Context: (E)xit or (I)nfo
1	Median length of stay for children in foster care (out-of-home placement)	P		CWS/CMS	<p>DCFS Benchmark - 516 days</p> <p>E</p> <ul style="list-style-type: none"> <li>Number of children in placement is those who were actively in out-of-home placement as of the last day of the reporting months.</li> <li>Excludes- Guardian homes, adoptive placement, non-foster care placements, kin-gap, probation, private adoption, and revenue enhancement cases.</li> <li>Median days based on the most recent removal date and last day of each reporting month (report date).</li> </ul>
2	Number of children in congregate care settings	P		CWS/CMS	<ul style="list-style-type: none"> <li>Total number of children in congregate care settings (children placed in group homes) who are actively in congregate care placement as of the last day of the reporting month.</li> <li>Total number of children in group homes will be broken down by RCL (Rate Contract Level)</li> </ul>

PERMANENCY							
	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/National Standard	Context: (E)xit or (I)nfo	Data Indicator Description
3	Number of children exiting foster care by termination reason type	P		CWS/CMS		I	<ul style="list-style-type: none"> <li>Based on Placement Episode Termination reason type.</li> <li>Excludes Placement episodes that are 5 days or less.</li> </ul>
4	Reunification within 12 months – Of all children discharged from foster care to reunification during the year who had been in foster care for 8 days or longer, what percent were reunified in less than 12 months from the date of the latest removal from home?	P/F		CWS/CMS	National standard - 75.2%	E	Percentage of children discharged to reunification within 12 months of removal.
5	Adoption within 24 months – Of all children discharged from foster care to a finalized adoption during the year, what percent were discharged in less than 24 months from the date of the latest removal from home?	P/F		CWS/CMS	National standard - 36.6%	E	Percentage of children adopted within 24 months of removal.
6	Reentry following reunification – Of all children discharged from foster care to reunification during the year, what percent reentered foster care in less than 12 months from the date of the earliest discharge to reunification during the year?	P/F		CWS/CMS	National standard - 9.9%	E	Percentage of children reentering foster care within 12 months of a reunification discharge.

PERMANENCY							
	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/National Standard	Context: (E)xit or (I)nfo	Data Indicator Description
7	Children with 2 or less placements in less than 12 months in care	F		CWS Outcomes Systems Summary – UC Berkeley	National standard - 86.0%	E	<ul style="list-style-type: none"> <li>The percentage of children with 2 or fewer placements in foster care for 8 days or more, but less than 12 months;</li> <li>Time in care is based on the latest date of removal from home;</li> <li>The denominator is the total number of children who have been care for at least 8 days but less than 12 months; and</li> <li>The numerator is the count of these children with 2 or fewer placements.</li> </ul>
7a.	Within 12 – 24 months	F		CWS Outcomes Systems Summary – UC Berkeley	National standard - 65.4%	E	<ul style="list-style-type: none"> <li>The percentage of children with 2 or fewer placements in foster care for at least 12 months, but less than 24 months;</li> <li>Time in care is based on the latest date of removal from home;</li> <li>Denominator = the total number of children who have been in care for at least 12 months and less than 24 months; and,</li> <li>Numerator = the count of these children with 2 or fewer placements</li> </ul>
7b.	At least 24 months	F		CWS Outcomes Systems Summary – UC Berkeley	National standard - 41.8%	E	<ul style="list-style-type: none"> <li>The percentage of children with two or fewer placements in foster care for 24 months or more;</li> <li>Time in care is based on the latest date of removal from home;</li> <li>The denominator is the total number of children who have been in care for 24 months or more; and</li> <li>The numerator is the count of these children with 2 or fewer placements.</li> </ul>

WELL-BEING					
	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark / National Standard
					Context: (E)xit or (I)nfo
1	Children in out-of-home care per 1,000		TBD		<ul style="list-style-type: none"> <li>County's out-of home care rate for a given year is computed by dividing the County count of children in foster care by the County's child population and multiply by 1,000.</li> <li>Out-of-home care rates are based on children under the age of 18; therefore, they do not directly correspond to the total out-of-home care rates.</li> </ul>
2	Number of children placed w/in 10 miles of home (from which they were detained - excluding relatives) and in excess of 10/20/30 or more miles)	P	CWS/CMS		<ul style="list-style-type: none"> <li>Examines the distance, in miles, between a child's removal home address and the child's first placement address for all children who are still in care 12 months after entry.</li> </ul>
3	Siblings placed together in foster care	P	CWS/CMS		<ul style="list-style-type: none"> <li>Percent of sibling groups in foster care who are placed with some or all of their siblings: <ul style="list-style-type: none"> <li>Identified breakup of siblings into multiple placement home;</li> <li>Breakout by placement homes and sibling groups;</li> <li>Includes family count and child count;</li> <li>Siblings are determined by a 7 digit serial number; and</li> <li>Placement homes are determined by unique placement home records.</li> </ul> </li> </ul>

WELL-BEING						
	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark / National Standard	Context: (E)xit or (I)info
4	Number/percent of runaway children	P	CWS/CMS	DMH Data Warehouse	1	<ul style="list-style-type: none"> <li>• Number of outstanding runaway children as of the last day of reporting month in the out-of-home care population.</li> <li>• Percent of runaway children <ul style="list-style-type: none"> <li>◦ The denominator is the number of runaway children/The numerator is the total number of children in the out-of-home care population.</li> </ul> </li> </ul>
5	Children in County who receive services from DMH/number of children served by DCFS and receive DMH mental health services - in County/out of County	P		DMH Data Warehouse	1	DMH to identify “in-County/out-of-County” data elements and insure they are in Data Warehouse/Cognos Cube.
6	Number/percentage of children with psychiatric hospitalizations	P		DMH Data Warehouse	1	DMH to identify Provider & Reporting Unit number for calculation.
7	Number/percentage of children entering the juvenile justice system	7	CWS/CMS		1	<ul style="list-style-type: none"> <li>• Number of children in out of home care for the reporting month whose placement episode closure reason was incarcerated.</li> <li>• Percent of children entering juvenile justice system: <ul style="list-style-type: none"> <li>◦ Denominator is the number of children in out of home care for the reporting month whose placement episode closure reason was incarcerated.</li> <li>◦ Numerator is the total number of children who had placement episode closure during the reporting month.</li> </ul> </li> </ul>

## **MENTAL HEALTH SERVICE EXPENDITURES**

<b>MENTAL HEALTH SERVICE EXPENDITURES</b>						
	Data Indicator	Category	Tracking Intervals	Data Source	Benchmark/National Standard	Context: (E)xit or (I)nto
1	Total expenditures by fiscal year	C		DMH Data Warehouse	I	Note: For all indicators listed below, it is important to keep in mind that different services have different reimbursement rates (i.e. outpatient therapy costs less than a day in an inpatient unit)
2	Total units of mental health service by fiscal year	C		DMH Data Warehouse	I	
3	Total expenditures by service category (day services, inpatient, outpatient)	C		DMH Data Warehouse	I	
4	Total expenditures and units of service by place of service(POS)	C		DMH Data Warehouse	I	
5	Total expenditures by gender	C		DMH Data Warehouse	I	
6	Total expenditures by age group	C		DMH Data Warehouse	I	
7	Total expenditures by SPA of origin	C		DMH Data Warehouse	I	DCFS to provide DMH with SPA of origin
8	Total expenditures and units of services by SPA of treating provider	C		DMH Data Warehouse	I	

Category Codes:

- P: Catherine Pratt Indicators
- 7: Big Seven Indicators
- F: CFSR Indicators
- C: Cognos Cube

Operational Efficiency Codes:

- ND: Newly Detained
- NOD: Newly Opened/Non-Detained
- EO: Existing Open

<b>PROJECT DATA SHEET</b>	
<b>Project Name:</b> #18- Qualitative Service Review (QSR)	
<b>Start Date:</b> 3/1/09	
<b>Sponsors:</b>	
Olivia Celis-Karim, DMH, Deputy Director Lisa Parrish, DCFS, Deputy Director	
<b>Project Managers:</b>	
Marilynne Garrison, DCFS Brian Bruker, DCFS Norma Fritshe, DMH	
<b>Background:</b>	A Qualitative Service Review (QSR) is one of the components of the County's exit criteria from the Katie A. class action lawsuit. A three-pronged approach is proposed to exit from the lawsuit consisting of: 1) successful adoption by the Board of Supervisors/Court of a meaningful strategic plan; 2) passing score on a QSR; and 3) acceptable progress on a discrete set of data indicators. The QSR will be used to evaluate the quality of practice through child status and system performance indicators, based on this practice of evaluation developed by the Child Welfare Policy and Practice Group as well as the actual instrument developed by Human Systems and Outcomes, Inc. Los Angeles DCFS and DMH staffs visited Utah in November 2008 to observe their QSR process, and are planning to implement a QSR process in late 2010 as part of our exit criteria to document system performance improvement under the Katie A. Strategic Plan.
	<b>Expected Operational Date:</b>
1. Phase I: Develop parameters for a QSR, identify staff responsible for development of a protocol, identify training resources and funds, identify and train lead reviewers, and plan for implementation.	7/1/10
2. Phase II: Begin phased implementation of QSR by DCFS regional office in September 2010 (one office per month, skipping July, August and December each year), finishing the 18 DCFS regional offices in July 2012, with a final report issued by December 15, 2012.	9/1/10 – 12/15/12
3. Phase III: Re-review any offices with unacceptable levels of performance, complete and issue follow-up report by December 15, 2013.	12/15/13

**Expected Outcomes:**

1. Phase I: A QSR protocol which coherently and efficiently integrates this new process within the Quality Improvement/Quality Assurance framework by: 1) clearly delineating obligations and work flow at DCFS; developing a trained infrastructure to fulfill the obligations of the QSR, roll-out a plan; and supervise and conduct reviews and produce follow-up reports.
2. Phase II: Initiate a Countywide rollout of QSR using a sample of cases from each DCFS office, produce QSR reports for each office, and a final report on QSR outcomes and successes or opportunities for program improvement strategies.
3. Phase III: Follow-up reviews will be conducted at offices with unacceptable levels of performance and a follow-up report will be developed.

**Deliverables:**

<b>Phase I</b>		<b>Project Lead(s):</b>	<b>Planned Timeline:</b>	<b>Status</b>
1.	Hire a CSA II at DCFS to head a new Quality Improvement Section.	Marilynne Garrison	3/1/09	Completed
2.	CSA II to explore existing QSR processes in other jurisdictions to identify promising protocols	Brian Bruker	6/1/09	In progress
3.	Identify funds available to support QSR training and consultation from other jurisdictions	Brian Bruker	7/1/09	In progress
4.	Procure consultation Services form HSO and other jurisdictions to assist with QSR start up activities	Brian Bruker	9/1/09	Pending
5.	Create protocol, tools and identify roles/responsibilities for implementation	Brian Bruker	4/1/10	Pending
6.	Create roll-out plan for implementation, and purchase consulting resources to conduct reviews	Brian Bruker	5/1/10	Pending
7.	Identify county staff to collaborate in reviews	Brian Bruker	7/1/10	Pending
<b>Phase II</b>				
1.	Complete reviews of three (3) DCFS offices	Brian Bruker	12/1/10	Pending
2.	Issue preliminary findings from first three (3) reviews	Brian Bruker	1/15/11	Pending
3.	Complete reviews of six (6) more DCFS offices	Brian Bruker	7/1/11	Pending
4.	Issue preliminary findings for all eight (8) offices	Brian Bruker	9/15/11	Pending

5. Complete reviews of nine (9) final DCFS offices	Brian Bruker	7/1/12	Pending
6. Issue preliminary findings for all eighteen (18) DCFS offices	Brian Bruker	9/15/12	Pending
7. Issue final report on all eighteen (18) DCFS offices	Brian Bruker	12/15/12	Pending
8. Re-review any offices with unacceptable levels of performance, complete and issue follow-up report (can do nine [9] offices in one year, two year cycle to do all eighteen [18] offices)	Brian Bruker	12/15/13	Pending

**Resources:**

1. Existing staff at DCFS to support development of the protocols, tools and implementation plan.
2. Staffing at DCFS to plan and schedule meetings and reviews for individual offices, and to supervise and conduct reviews, focus groups and interviews.
3. \$1.5 million budgeted in FY 2010-11 for costs of QSR. Will propose \$300,000 from FY 2008-09 savings be used to conduct pre-implementation activities in consisting of:
  - Contract for a customized QSR instrument that meets the needs of Los Angeles County;
  - Pilot test the instrument and make any refinements needed; and
  - Identify, train, and certify qualified reviewers to conduct the administration of the reviews.

**Dependencies:**

1. Phase I: Funding for purchase, training and consultation on QSRs from outside jurisdictions.
2. Phase I: Other staff to support proposed DCFS QI/QA Manager, Brian Bruker in creating protocol and implementation plan.
3. Phase II: Successful training on and roll-out of CSAT, MAT, and CFTs for the regional offices.
4. Phase II: Successful implementation of screening, assessment and service linkage strategies in the offices.
5. Phase III: Successful completion of Phase II by December 2012.

**Issues and Risks:**

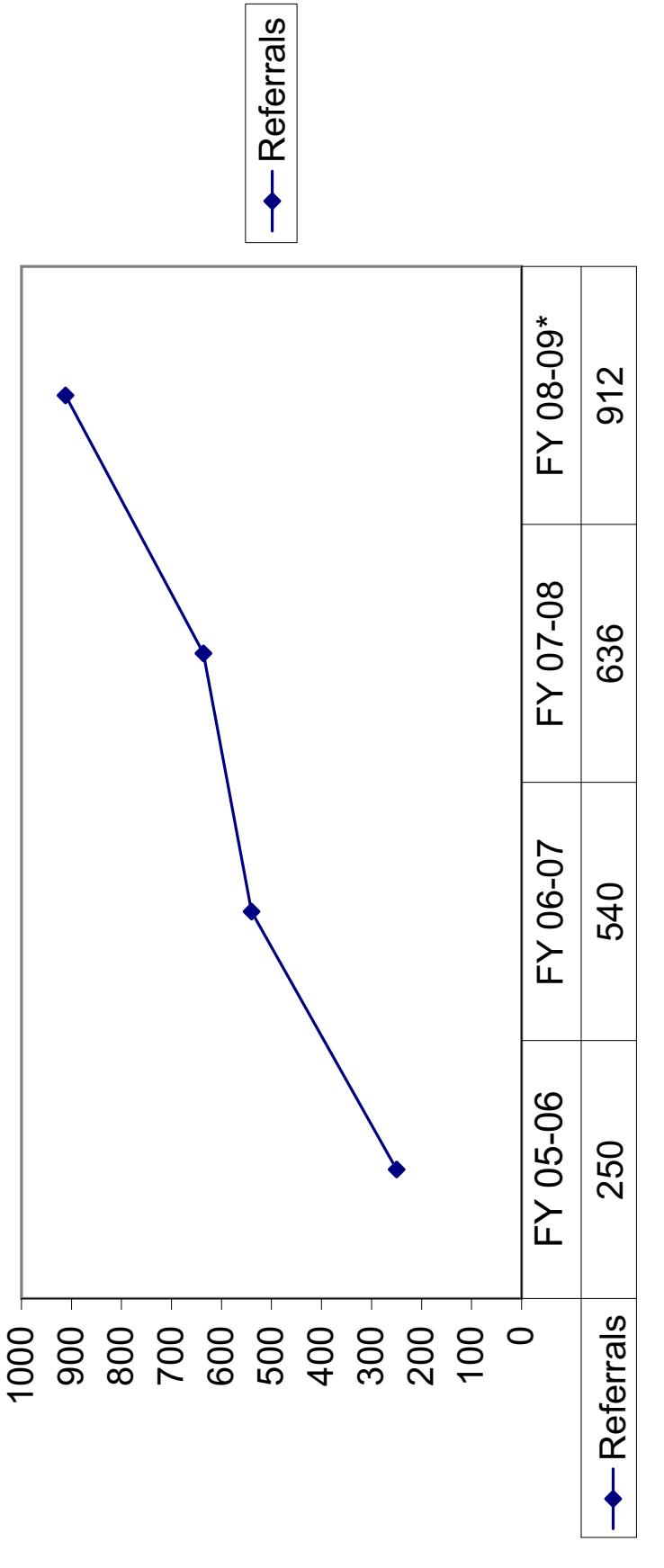
1. No resources identified in Katie A. Strategic Plan budget, proposed budget request currently under development.

PROJECT TEAM MEMBERS		
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## Attachment B

### MAT Referrals by Fiscal Year



Data Source: DCFS MAT Referral and Completion logs through June 2008 and DMH Logs from July 2008 to Jan. 2009

Created by: Laura Andrade, Ph.D., MAT Program Manager

Report Date: March 18, 2009

\* FY 2008-09 is current through Jan. 2009

## **Attachment C**

### **Wraparound Vignettes for Tier I and Tier II**

#### **1. Example of a referral that would be appropriate for Tier I Wraparound**

An example of a Tier I child (i.e., a child that is in or at imminent risk of placement in a RCL 10 or above) would be **M.** -- a 16-year-old girl who was sexually abused as a child and has been in the custody of DCFS since she was 8 years old. The whereabouts of her father is unknown and her mother is in prison related to a history of chronic substance abuse. She has had multiple foster and group home placements (15 in total) and three hospitalizations. She has a history of depression, poly substance abuse, stealing, prostitution and self-mutilating behavior. **M.** is currently placed in a RCL-12 and her CSW is making a Tier I Wraparound referral in order to facilitate her safe and successful return to the community and the home of a recently identified family member.

Below are examples of Tier I Wraparound type interventions for a youth like M.

Based on the presenting strengths of M and the relative care giver, the other members of the Child and Family Team (CFT) and the CSW, the team would create an individualized Plan of Care that would pair strengths with the identified underlying needs that are driving M's behavior. Those could include, but are not limited to:

1. Providing individual therapy, such as trauma-focused cognitive behavior therapy, for M related to her history of abuse.
2. Providing therapeutic behavioral services in the relative's home to assist M in transitioning to her new environment
3. Providing a parent partner to work with the relative caregiver, who may not understand the needs of M.
4. Providing linkages to family therapy, as needed.
5. Providing educational support to get back into a public school.
6. Developing a process, with the CFT, to understand the underlying needs behind the self destructive behavior, address triggers and develop 24/7 crisis response plans.
7. Developing strategies that pair M's strengths and needs to create successive approximation opportunities for growth and "seeing there is another way."
8. Providing flex funding to support those activities that are not covered by other funding streams. For example, M loves to do hair and has aspirations of being a hair stylist. The team would create an opportunity for M to practice and refine her skills by either paying for her to get additional schooling, or work with a local beauty shop to allow M to practice, or earn some money.
9. Providing housing support for the relative caregiver in caring for M. This may look like anything from paying rent for a larger apartment for a short period of time to buying an additional bed.

## **2. Example of a referral that would be appropriate for Tier II Wraparound**

An example of a Tier II child (i.e., a DCFS child that has EPSDT and is experiencing intensive mental health needs that are impacting their educational and social functioning) is J. -- a 10-year-old boy who has recently come to the attention of DCFS after being removed from his mother's care, along with several siblings, due to neglect. He has a history of multiple school suspensions, running away and nocturnal enuresis. He has been living with his aunt and uncle for six months, but is having difficulty adjusting and his behavior has been escalating since his mother had a set back at her in-patient drug treatment program. J. has been in outpatient, individual therapy for five months with little progress and was hospitalized recently after stating that he wanted to kill himself. His CSW has made a referral to Tier II Wraparound in order to save J's placement with his aunt and uncle and facilitate his return to mother following her successful completion of her drug treatment program.

Below are examples of Tier II Wraparound type interventions for a youth like J.

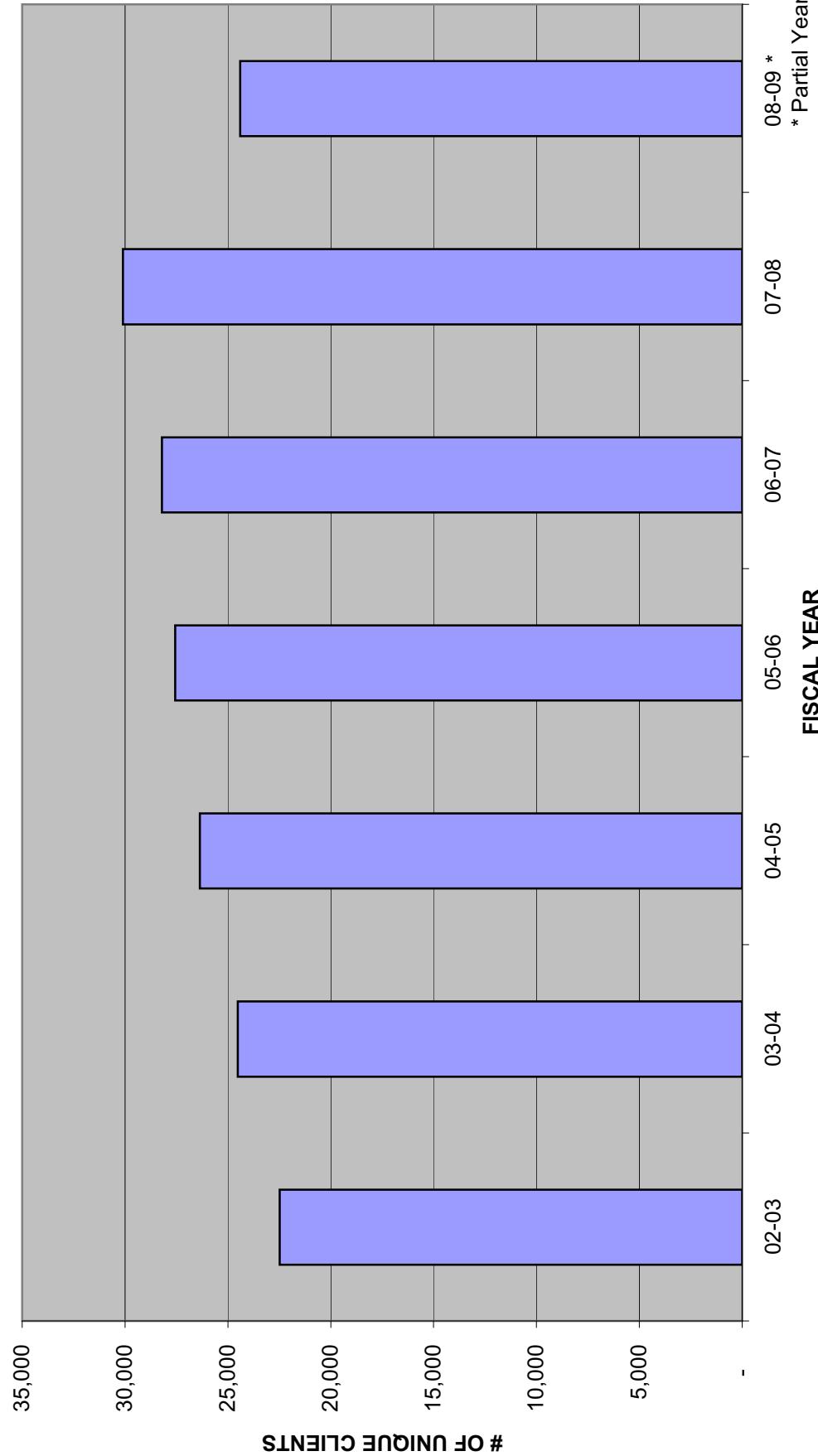
Based on the presenting strengths of J and his aunt and uncle, the other members of the Child and Family Team (CFT) and the CSW, the team would create an individualized Plan of Care that would pair strengths with the identified underlying needs that are driving J's behavior. Those could include, but are not limited to:

1. Providing intensive in-home treatment, including mental health and rehabilitative services for J.
2. Providing a parent partner to work with the aunt and uncle, who may not fully understand the needs of J.
3. Provide family therapy for J and his mother upon her return from drug treatment.
4. Providing educational support, in the form of mentoring and tutoring, to keep J in school.
5. Developing a process, with the CFT, to understand the underlying needs behind the self destructive behavior, address triggers and develop 24/7 crisis response plans.
6. Developing strategies that pair J's strengths and the needs to create successive approximation opportunities for growth and "seeing there is another way."
7. Working with J's mom to provide outreach and support.

**Attachment D**

**LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH**

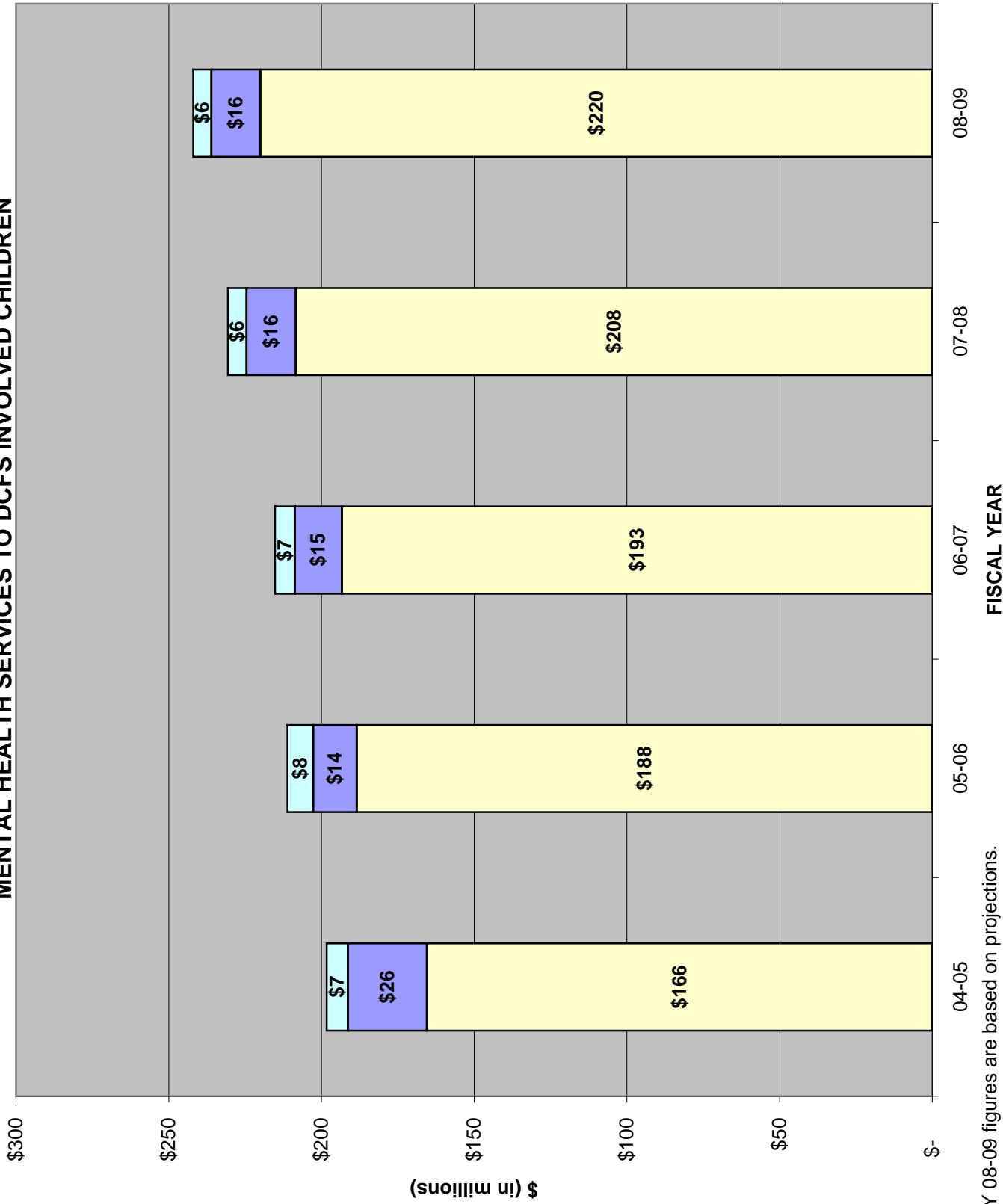
**MENTAL HEALTH SERVICES FOR DCFS INVOLVED CHILDREN AND YOUTH**



**Attachment E**

**LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH**

**MENTAL HEALTH SERVICES TO DCFS INVOLVED CHILDREN**



\*FY 08-09 figures are based on projections.